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EMOTIONAL MATURITY

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THE word "maturity" as it is used today represents a value gradient and as such embodies concepts and attitudes which become the matter of proper concern for the philosopher and the theologian but about which the scientist is not equipped to speak; for the scientist, working as a scientist, has as one of his principles that as far as he humanly can, he shall treat, and present his data as he finds them and refrain from attitudes and judgments toward that data which stem from other areas of his life. The following statements, consequently, are made with hesitation and with apologies. By no means do they represent final formulations.

For the purpose of opening a discussion on "emotional maturity" as a goal for educational efforts both in the family and by extra-familial authorities, it might be well to realize that this concept of maturity is based on the findings of applied biology and has only recently been included in psychiatric and psychological studies. It is, therefore, subject to all the conceptual dangers and misunderstandings, ideological cloudiness, and logical fallacies inherent in any argument by analogy accompanying the transfer of a terminology shaped to cover the truths discovered in one field of endeavor to the phenomena observed in another.

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The present task of relating such a concept, in itself to some degree a misnomer, to formulations of another discipline, and seeking to understand or discuss "emotional maturity" in the light of the doctrine of perfection of the Christian theologian confronts us with all the difficulties inherent in any effort to relate concepts appropriate to a value system and derived from it to those of a scientific frame of reference, which, as has been pointed out, remains, as far as possible, value free.

The concept *maturity*, as it is used by the scientist, refers to an individual rather than to a group. It denotes a state in which the successive stages of development regarded as necessary for the full growth of the biological specimen under observation have been traversed, that is, approached, achieved with difficulty, maintained for an appropriate length of time, and abandoned — often with pain — for the sake of a new and higher, (i.e., more complex) organization, function, and equilibrium. Former stages leave their traces in this course of development, but these residuals are integrated into the mature state to such an extent and in such a manner that they do not interfere with any or all of the functions of the fully grown individual.

To illustrate: at the somatic level we may remind ourselves that in his ontogenesis each individual traverses a great many levels of phylogenetic development. For example, the appendix is a remnant of a much larger intestinal organ formerly of service, remnants of the gills are to be found in the neck area, and there is the prenatal hair which covers the body of the foetus. All these represent such phylogenetic stages repeated in the life of the individual. In the somatic field, these residues are of no concern, or would not be, were it not for the fact that they are vulnerable points, liable to the appearance of future difficulty, as we well know from the incidence of appendicitis and from the development of certain neck tumors. There may also be oddities of development in which a stage ordinarily traversed without significant residue will persist or assert itself. Examples of this are the lion man or the human gorilla shown as freaks in sideshows and circuses. These brief biological references may furnish us with some leads for a consideration of personality development from infancy to adult years.

To summarize: maturity is reached through a succession of stages, each appropriate for its level, each having manifestations consonant with the level of organization it represents, each attained with difficulty, and each destined to be reduced to a residual, often so insignificant that it almost escapes observation; but it nevertheless becomes integrated into the subsequent stage or stages of development and may represent vulnerable points prone to illness or may reassert itself under conditions or stress at a time when it is inappropriate or out of harmony with the state of growth existing in the rest of the organism and is then often labeled "immature."

The term "immature," as it is used by the scientist, has no value reference. An immature bird is one which has not yet reached its full size

and strength and its full range of performance. It is only when former levels of performance appropriate to an earlier stage of development and consonant with the level of growth then attained persist or reassert themselves at a time when full maturity in all functions and in all members is demanded by the observer that we sometimes speak of immaturity in a somewhat devaluating sense. In other words, the gradient between the performance expected from an individual under the circumstances prevailing at that moment — what we expect from him on the basis of his social, educational, ethical, and religious background — and his actual performance is often described in terms of degrees of immaturity.

It should be clear from these remarks that what we call maturity depends upon the expectations impinging on a given individual from those around him, and that the more we ask of him in terms of level of performance the greater is the opportunity for the so-called immaturities to become manifest. One might even say that the curve of growth in terms of better and better standards of performance is equalled by a series of stages of demands placed on the individual because we have come to expect a certain kind of behavior at each of the different stages of development. What we permit a child to do can not be permitted the adult because we demand from the latter greater responsibility and entrust to him greater power. To cite a very simple example: every young mother spends minutes several times each day patiently — or rebelliously — massaging her baby's spine or spanking it gently to "bring up the bubble." And when the desired reflex has been attained, her eyes, her voice, her words, her face, every muscle tonus in her whole body shouts out to the child her relief and gratification. A few weeks later she is saying proudly — and in the hearing of the child — "Joanie can burp herself now." And a very few, very short, months later she is saying to the toddler, "Joan! Excuse yourself! That isn't nice. If you can't keep from belching, leave the room!" In other words, that which is desirable for a child of two week is outmoded for one of six months, and intolerable in a lass of two. But remove the context of demands in which the given person is operating (as you may see in the course of psychoanalysis where everything — or *almost* everything — is permitted again as it was once in the days of childhood) or suggest in hypnosis that again it is all right to behave like a child of three and, as every psychoanalyst or psychiatrist knows, you will again see a rapid return of ways of acting, thinking, feeling, and speaking characteristic of and appropriate to stages of development supposedly outgrown and long given up.

The equilibrum, then, between the demands for excellence in performance and the capacities to operate according to these standards seems to be the core of the problem of maturity.

In contrast to the clergyman, the psychiatrist is inclined to describe not so much the maximum of excellence in maturity which can be reached but rather the *minimum* standards which would be expected from an individual in our society. These will probably be colored by the

traditional values of the middle class or upper middle class (of which most professional people are members) and their ethical and religious backgrounds.

Granted such a value gradient based upon the precepts and percepts acquired by virtue of having grown up in a middle-class West European or American environment with all its culturally and religiously-toned goods and goals, the following criteria may be chosen for discussion as representing at least some of those which would be salient in a person regarded as mature, that is, one who has reached adult years with adequate intellectual endowment, reasonable exposure to current educational advantages, and possesses a moral code consonant with his religious and social background.

First, such a person will be reasonably content. That is, he will be able to look upon his life and his society without a destructive degree of pain, despair, hostility, frustration, or yearning for that which, for the time being at least, is unobtainable, and without overweening pride, confidence, or satisfaction in those desirable and delectable things which are at his command, and without blindness to those assets and faults which he possesses or are inherent in his society.

Second, he will be able to perform the tasks put before him by himself and by his society in such a way that he makes full use of his equipment and materials presented to him without having his efforts hampered by his own tensions and emotional strains and his results marred by his inability to make full use of his capacities or by inappropriate modes of attack or by too greedy or too childlike demands for recompense, particularly for recompense in terms of love, admiration, prestige, power, support, or money not warranted by the task at hand.

Third, he will be able to operate under the ordinary stresses of life with only that degree of strain consonant with the effort or deprivation demanded by the crisis at hand. That is to say, he can go to school, fall in love, marry, have a child, endure sickness, nurse a loved one through an illness, meet death, separation, disillusionment, disappointment, postponement, and frustration without having to disintegrate or compensate with the development of a symptom which will alleviate or serve as an alternate avenue of discharge for the energy and tension which have been mobilized by the experience.

Fourth, he can operate so he does not have to make others sick or impair their capacities to live happily and productively and constructively either by depriving them of some element of support, freedom, love, reward, or self-confidence needed for their well-being and optimum performance or by so depleting them by his own inordinant demands for service, admiration, devotion, or reward that they have little or no energy left to carry on their own tasks and maintain their own sense of productive and reasonably integrated well-being.

Our society demands individuals who can be a contributing and not

a disturbing or disrupting member of the group or groups in which they have to operate, but it must at the same time be recognized that to be integrated to one's group, whether it be family, friends, work team, or any of the groups which form our political and cultural institutions, is a sign of maturity only if these groups themselves have a structure expressing the standards of maturity of which we have been speaking for the individual. We know only too well that at this point in our culture there are inevitable sources of tension and distress which the mature person must be able to handle. We also know that there are some groups so wrong that only a sick man or a distorted one can be content to remain in them and conduct his life and activities within their frame of reference without pain and dissatisfaction. In other words the mature person must be integrated in his groups yet have enough perspective to evaluate them and to become an active source of change within them so that the group or institution may be kept from decay. Linton and Kardiner, in their *The Individual and His Society*, have pointed out that an institution consists of those codes and patterns of behavior evolved by a culture to meet the needs and capacities of its members, modifying those needs and capacities by gratification or its lack, and in turn being modified and changed by the mutant needs thus gratified.

It must further be recognized that extremely difficult decisions may be required of the mature person when he is forced to take a course of action which appears correct in a wider frame of values but which, for the time being, is contrary to accepted group standards. This has long been recognized as one of the most painful of human predicaments and one most likely to bring retribution from the outraged culture: the lions did not all die out with the martyrs and even the saints found them uncomfortable companions. Again we are confronted with the problem of balance between group maturity and individual maturity.

To meet these criteria an individual has to grow through the various stages of his development, enjoying the satisfactions and attaining complete mastery of the skills and achievements appropriate to each stage. A mature group is required in order that the growing individual be permitted the kind of behavior suited to the various stages of his growth for the various amounts of time required for him to master that stage and step forward to a higher level of integration. This guidance permits expression of immature behavior patterns for a sufficient length of time to allow the child to master them by practice and effort. It also provides an adequate example of behavior patterns (and a sufficient number of them) for flexibility, choice, and enough affection to allow the wish to emerge in the child to emulate the loved adult and to be appreciated by him. Mature parents must have these capacities in order to be appropriate and constructive guardians of a growing child. The parents must know enough about the variations of behavior which occur at different stages of growth, and approximately when to expect them, so that they do not become unduly tense or frightened by the anticipated permanency of such behavior. They must also be sufficiently secure with their friends,

relatives, and neighbors to support emotionally the child who shows the immaturities appropriate to his age. Furthermore they must not prematurely demand from the child that which is beyond his development. If they do, they must be prepared to have the residues of earlier stages emerge in an apparently well-integrated and mature person at inappropriate or unexpected times. *Pseudo*-maturity (which often is essentially nothing but outward conformity to adult behavior patterns without genuine mastery of their meaning, their occasions of applicability, and of their possible and permissible mutations — and without genuine transcendence of earlier stages) is achieved only by repression. Such a semblance of maturity, a facade — fragile and always under threat of decomposition if pressure becomes too great is obtained by excluding from consciousness impulses and temptations which with better guidance might be mastered by adequate and reliable control. That which has been repressed has *not been brought under control.* It has not been mastered — robbed of its fangs, as it were — nor transmuted. Thus the energy bound up in the repressed item is not available for redirection into constructive and productive endeavors, and furthermore the repressed material is quite likely to emerge, distorted and disguised, in inappropriate places and at awkward and destructive times.

It seems important at this point to elaborate a bit on the positive side of the whole question of maturity and its criteria. As we have said, the residues of earlier stages of development may cause trouble, but these very stages of early development which must be transcended and which, mishandled or cut short, can become noxious foci in the maturing individual are also the foundations for that richness of experience and expression which must survive and be operative in the mature adult if we want him to be that contributing and creative and productive person whom we desire. The mature person, for example, is not marked by the absence of fear but by his capacity to feel deep anxiety and to tolerate it and master it. Those deep desires for affection, for caring for others and being cared for by them, the longing for closeness to others, the wish to be appreciated and enjoyed and recognized as somebody worthwhile in his own right which mark the early stages of development in the small child must also be felt keenly by the mature adult. The difference between the child and the adult lies in the use to which these desires are put. That is to say, in the adult they appear in a more complex scheme which has among its elements a broader framework of goals and the inclusion of more human beings within its scope.

Let us consider another basic emotion, that of anger. The mature adult must do something about his hostility when it is aroused, something *constructive* rather than destructive or inhibiting, even though the doing something includes aggression towards another or a group of others! To be aggressive wisely and in the right directions, in the right manner and at the right time, and toward the right persons or things is one of the principle characteristics of maturity. On the other hand pacific tolerance and indulgence of the wishes, actions, or whims of another *at any cost*

may often be a sign *not* of maturity but of repression or helplessness. What, for instance, can a three-year-old punished for something done by an older brother, do with his frustration, his anger, his sense of outraged integrity, his awareness of unearned retribution, his perception of injustice?

Often the psychiatrist feels that he is confronted by individuals who seem to possess a type of perfection which can and has been described as as an ideal in the Christian community. Frequently, however, when such a person's behavior is more closely scrutinized, it is seen to be possible not because they have mastered the undesirable responses and urges but because they have *driven underground* those energies and forces which otherwise and more normally would be expressed in some form of constructively aggressive behavior. For example, we all know the overtly friendly person, all smiles and willingness to please, but who somehow seems cold and empty — about whom there is something awry. We feel that, for some reason which we don't quite understand, he is not to be trusted. Or perhaps we know a punitive martyr, the willing self-sacrificer who rules everyone in his — usually *her* — environment with a rod of iron. We some times encounter a disguised hostility which has become distorted and manifests itself as witch hunting or in the form of scape-goating.

This emotional handicap may also show itself as frigidity in the love life, inability to be hostile even when there is ample justification. Both are often expressions of having stopped development towards mature expression of drives toward sex or aggression because of a serious fright, often called "traumatic experience." Sometimes such a trauma comes from the deprivation of sufficient psychological nutriment, for example, when a person has not been given enough ways of handling his experiences, or from over-stimulation, that is, excessive provocation at a time when the person was too young, too weak, too immature, too inexperienced to understand or handle the situation. The result of such an experience is the creation of an island of immaturity. The individual has been compelled to abandon any further dealings with these forceful drives and seeks, therefore, to avoid any occasion which might bring them about since he feels he can do nothing about them when he does meet them.

Such islands of immaturity in an individual who impresses the observer as otherwise being mature may come into the open only at the occasion of a crisis, a time when the legitimate expression of these drives is expected as, for example, the exercise of sexuality in marriage or aggressive behavior when the person is faced with the maintenance of standards against a disturbing infractor or is the victim of unearned provocation or hostile acts. The absence of satisfaction and the accumulation of tension resulting from such stimulus without appropriate response or transmutation of the energy into an acceptable form and its expression may then lead to secondary distortions of the whole personality and open the door to a neurosis.

A second common impairment of richness and depth of personality seems to be related to the sort of impoverishment which comes from an insufficient number of models to love and to emulate and to integrate into the personality of the growing child. The scientist, for example, may be very competent in his laboratory and appear extremely mature at scientific conferences when he meets and talks to the few people in the world who understand and respond to his own language but that same scientist may be severely impoverished in all his other human relationships. He may not know, for instance, how to talk to and how to feel for and toward the members of his own family or to any other person in his community who does not happen to share his language and his preoccupation. He may then retreat from all human contact and wall himself off — an end very easily attained simply by acting as though in one area at least one knows so much he can not possibly communicate it to lesser mortals, or by surrounding oneself with the aura of secret knowledge.

One of the reasons for the emphasis laid upon the family in any discussion of emotional health or maturity is that it is the primary group; the immediate family, the small nucleus of father, mother, child, and possibly brothers and sisters, takes on such importance because it is the one met when the child is vulnerable, dependent, and can't possibly run away. No matter what they do or fail to do, he must submit and must bear the consequences. And often those consequences stem from the mistaken efforts of his family to spare him and give him the best of all possible environments and upbringings, but the efforts have misfired. For instance, the parents who considered other children in the street bad company and hoped that they alone would be suitable and satisfying models for the child have prevented him from mastering the social skills necessary for human relations of sufficient diversity, skills which can be obtained only through acquiring and practising the various modes of behavior suitable for the divers kinds of human beings whom he will encounter all his life. The bad language, the small silly jokes, the naughty little stories, the slang, the occasional uncouthness of idiom, the rare grammatical slip which the child brought home from the street, the awkward pronunciation or transitory unpleasing accent may be forbidden and condemned as utterly and irrevocably bad rather than being identified for the child as suitable perhaps for certain activities and in certain places and among certain peoples but not to be blindly adopted and indiscriminantly used. The rich person, on the contrary, has loved and emulated many people, has learned to discriminate those traits which he has seen in all those people whom he has loved and admired, has tested for himself what parts of their behavior and attitudes fit him and in what groups they are appropriate, and has gradually abandoned those traits not adapted to his course of life. He has abandoned not only the bad habits of childhood but has also left behind some of those traits which were once highly praised by his elders and which are still desirable, appropriate, and good for an earlier age. Such a person does not have to respond to his drives by withdrawing from groups in which he might well

participate, to freeze up emotionally and retreat behind a nice safe wall. Instead, he can respond vigorously and appropriately when occasion arises and has a sufficient safety margin against the accumulation of undue emotional tension and sufficient alternate avenues of discharge so that he can enjoy and share the joys of many different kinds of people, whether they be found in the ordinary forms of daily acts, the usual tasks of daily living, or the highly refined pleasures of art and literature, or the depths of a shared religious experience.

Psychiatrists feel that it is one of the tragedies of our particular civilization that we have many efficient and successful men but few rich personalities. The excessive competition demanded for the development of wealthier, more varied, and speedier performance in a narrow area of endeavor, whether it be in business, science, research, academic, or professional life puts a premium on those individuals who set an increasing pace of production in one very limited area of the total potential for mature, productive, and creative living while the person who prefers a warm family life, rich friendships and varied activities to a — shall we say competitive sport's performance? — is often punished by lack of success and public acclaim. These go to the man who has speeded up the production line, sold more policies, developed a new tool, written more books, or published a scientific paper. The rewards for maturity in human relationships and the art of living certainly do not come automatically from the public. A man who prefers variety, depth, richness to quantity or pace must derive his satisfaction from the sheer act of living in a mature way. While the reward of persistent driving effort in one narrow field may be prestige, money, promotion, and fame, the *mature* person is likely to distribute his energies over a wider variety of activities and maintain a number of human contacts, finding his reward in the emotional satisfaction inherent in such a rich life, in the gratification inherent in the immediate experience of successful human interaction.

A final aspect of the mature personality which might be mentioned seems to be the fact that a person capable of living in a mature manner is likely to be deeply concerned with a *cause* to which he is devoted in partnership with others of his fellow beings. In a perhaps more familiar terminology, in some way he has learned how to lose his life in order to find it, to sacrifice his atom of selfhood and immediate intimate gratification for the sake of achieving a larger molar self and attaining a more remote and wider goal whose goods can be shared with others who have accompanied him in its pursuit and who have participated in its attainment. This may well take the form of service to those who are unfortunate or stunted in their growth or of efforts to change those features of our culture which show residues of former levels of development — for instance, our penal codes. Such a view of life may be expressed in a search for remedies for the social ills which are inevitably present in every community and which would seem to be inescapable in our current market-place society (to use the phrase so trenchantly attacked by Erich Fromm). These would seem to be avenues of expression appropriate for

every mature person who by virtue of his type of living has emotional energy at his disposal and can direct it to creative, productive, and constructive ends.

Summary

Four criteria have been mentioned as those which one would expect to be salient in any individual of adequate endowment and training thought to be mature. Such a person would be reasonably content, be able to perform the tasks put before him by himself and by society to the level of his equipment and training, be able to maneuver under the ordinary stresses of life without disintegrating, retreating, developing "symptoms," or distorting his reaction, and to operate so that he does not have to make others sick or impair their capacity to live happily and productively to the full of *their* abilities.

The importance of the immediate family has been stressed in providing support, models, training, and sufficient psychological nutriment for full and healthy growth. The detrimental effects of deprivation or over-stimulation have been mentioned. We discussed stimulus to hostile response and islands of immaturity, walled areas left undeveloped because of too great and overwhelming stimulus at a time when the growing individual was too frail to stand the impact or too unskilled in response to know how to handle the appropriate discharge whether that stimulus came in the field of sex or was one leading to the impulse toward aggression. We have pointed out some of the less successful alternative forms of expressing such repressed and distorted emotion: scapegoating, potential group leadership of violence masked as a righteous act against an invidious sinner, facade of friendliness and good will but without content or inner reality, martyrdom for the sake of the self and its distorted gratifications rather than sacrifice for a worthier and supra-personal cause. We have mentioned the possibility of symptom-formation, of guilt which is destructive rather than constructive, of crippling depression, we have described the emotional impoverishment which comes when the child must depend on only two or three models for ways of copying behavior. Usually these models are his parents who bear the limitation of being far ahead of the child in strength, knowledge, and skill. On the other hand many things, particularly ways of behaving toward others and learning social skills, can best be gained from copying a model *nearer one's own stature* — the well-known importance of one's peers. We have touched lightly upon the fact that one learns to behave not by precept or percept but by *imitating* those around him. We mentioned the scientist, impoverished both by islands of too great proficiency — his learning and specialized vocabulary — and of deprivation, ability to communicate only with the few, act only the role he thinks he ought to act, but who has no techniques for mobilizing the response he wishes from the members of his own family or from those in his community who do not share his special skills.

We have mentioned briefly other traits of the reliable or mature person, such as the ability to postpone gratification of a need, to plan for distant goals, to bear frustration, to be able to take risks, to tolerate a certain anxiety, and to make decisions — for all decisions carry a risk and involve abandoning certain goods for the sake of other, greater and more lasting ones. We have said that the mature person is able to make friends, to be sexually active and gratified within the limits set by his culture, that he is capable of getting mad and telling the right person that he is mad. Otherwise he is likely to alienate him much more by withdrawing, freezing up, or in some other way severing communication with him. We also have commented that the reliable person has a sufficient capacity to feel and manage his emotions, that he has a margin of safety to carry on creative activity for the good of the culture and for the pursuit of other, supra-personal or ultimate goals. Such a person is able to share the experiences and goals of others, to live vicariously, to be a member of a meaningful group, family, or friends, to be creative in one or two community enterprises not related to bread-winning, and to be active in the pursuit and experience of deeper, more spiritual (ethical and religious, if you will) goals.

We have warned against the predicament brought about by our competitive society which places so much emphasis on excess effort in a specialized field that an impossible standard is set for the rest, the rewards going to the one who pursues a *narrow* line, while the man who prefers healthy human relationships and a wider distribution of his effort is forced to fall behind and does not find himself numbered among the pace-setters and policy-setters. The question as to which is better, a high level of performance or a number of happy, constructive, creative people is not one for the scientist to answer because it is a *value* question and on that level he is not qualified to judge; he is equipped and trained only to see under what conditions such things are likely to occur and what happens when they do.

These observations are meant to be but an initiation, a stimulus, a curtain-raiser, as it were, for further thinking. What has been said is not intended to be either comprehensive or final. It is our hope, however, that there will continue to be a growing approximation of the efforts of psychologists, psychiatrists, and clergy which will do much to shift our emphasis from the remedying of illness and the patching up of broken lives (or removing the results of failure) to forward-looking, constructive planning for a program and a way of life which can provide the basis for the growth of mature — that is, effective, creative, productive, and constructive — individuals.

CHRISTIANITY AND PSYCHOTHERAPY: CONFLICT OR COOPERATION?

REV. OTIS R. RICE

CONFUSION and conflict obviously exist with regard to the respective concepts of psychotherapy and religion. Recent discussion has ranged from comfortable reconciliation of views to well-nigh open warfare. It is easy to see that an overly facile reconciliation of the disciplines of psychiatry and theology is as puerile as the complete repudiation of one by the other. It is also evident that in any attempt to appraise their differences and agreements emotional bias is present and considerable heat is commonly generated!

Much of the confusion and conflict derives from misunderstanding. The religionist receives a distorted version of the discoveries of dynamic psychology or encounters some psychological interpretations that come too close to his own repressed drives for comfort. He then repudiates all therapeutic efforts that are informed by these principles. Or the psychiatric worker encounters a distorted (or false) religious attitude or approach and is alienated from all religious concepts. It would seem unnecessary to stress the fact that in examining the functioning of either religion or psychotherapy one should make certain *what* religion and *what* psychotherapy is studied. For there are as many "sick" or perverted religions as there are psychiatric approaches that are equally unhealthy. Furthermore, the data of either discipline must be thoroughly digested and understood before any conclusions can be reached.

The worker will commonly meet several types of religion that are distorted, both theologically and psychiatrically speaking. One is the religion of "sweetness and light" — that dangerous emphasis in religion whose refrain is "All the world is lovely and I am lovely too!" Such an attitude is unrealistic and for the devotee, tragic in the extreme. No preparation for the reality of relationship, satisfactions, competition, stresses, and frustrations of our culture. No resources for the normal and abnormal crises of life. No means for understanding conflict and tension within the self. Another distorted religious pattern saddles its followers with a terrible burden of guilt and sense of sin but offers no means to achieve catharsis or the sense of forgiveness. Such emphasis simply reinforces the tremendous pathological guilt already present in the individual or group.

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There are numerous other unhealthy elements in cults and teachings commonly called Christian. It must also be emphatically stressed that many morbid patterns of behavior among apparently religious persons may not correctly be attributed to the effect of religion but rather are the result of misuse of religion by the sick or distorted personality precisely as he is known to misuse food or sex or politics.

Those who, in espousing the cause of religion, are critical of the findings and practice of psychiatry may be limited or mistaken in their understanding of the accepted and workable tenets of psychiatry. Erroneous or undisciplined thinking and poorly equipped or poorly trained practitioners vitiate the very cause they support. The philosophies and practices of some psychotherapists are deleterious. For example, a common malpractice is the violence that may be done to the integrity of the individual by forcing advice, decision, interpretation or action upon him, rather than permitting his own resources to be elicited for the solution of his problem. Another is the inability to understand or control or creatively use the tremendous emotional potentials present or released in therapy. Again the misuse or the inept handling of the powerful transference situation may produce unfortunate consequences. The objective observer must know whether he is dealing with crackpot theories put into practice by poorly trained, undisciplined or unprincipled practitioners.

Aims and Purposes

The end of psychotherapy is health. Contemporary therapists see individual health as related in some manner to the environment and the culture within which the patient lives. Words like "maturity" and "adequate adjustment" are used to describe this aim. Now health, both in the derivation of the word and in its present meaning, designates "wholeness." Psychotherapy therefore is a means of achieving or restoring that integration or completeness of personality to one who has suffered from conflict, disintegration, or blocked emotional development. This wholeness is not sought in a vacuum but in the specialized relationship with the therapist. If the therapy is successful it means a new interpersonal orientation with others within the environment and culture.

For sound Christian religion the aim is salvation — salvation of the individual and of society. Curiously enough this word also in its derivation means "wholeness." Christianity also covets maturity and integration. Such wholeness is to be achieved with respect to the self, to society, and to God. The salvation of the individual is seen as taking place within the context of a fellowship devoted to common worship, common works and common faith — the Church. The leaders and members of this society — clergy and laity alike — assume responsibility for sharing their experience with others and for "helping others" who are in need. This need as interpreted by churchmen may vary from a condition of spiritual darkness or sin through the whole gamut

to poverty and physical illness. In ministering to others (either in the pastoral and sacerdotal acts of the ministers or in the personal efforts of the laity) the structure of the relationship to individuals most closely approximates that of therapist and client.

It is obvious that the ultimate aims of psychotherapy and Christianity in respect to individuals and society are in a sense "impossible possibilities." In practical application both must accept the serious limitations of each situation and particularly the defects, immaturities and biases of those who attempt to serve others. To do the best possible in the circumstances is all that can be expected realistically. And the true idealist whether he be psychiatric worker or religionist is one who can see clearly the possibilities of individual or situation and strive to attain them while still recognizing the human limitations involved.

More and more the religious worker is disciplining himself by asking himself the question, "What are my aims in this situation?" Such factors as competence of the worker, age and intelligence of the client, family situation, local resources, seriousness of the problem must determine how the sights are set. Overly ambitious aims are now seen as wasteful and discouraging to all concerned. Yet the Christian worker never believes he strives alone with the human, situational factors but that there is an overplus of divine grace which may well achieve or reveal the possibility of more creative goals.

General Agreements

There seem to be several general areas of sound agreement between the two disciplines. Both agree upon the sacredness of the integrity of the individual personality and both recognize the terrible danger of violating this integrity, even with the best of intentions. Surely there is agreement that malpractice upon the human soul and personality is much more reprehensible than malpractice on the human body. Surely both see the possibilities of the misuse of the intimate relationships that exist in the privileged relationships in either field. In respect to the past there are only too many instances of serious disservice done by advice giving, authoritarian counseling, decision making, judgmental attitudes, as well as guilt and anxiety provoking approaches to the problems of others. It is recognized, also, that the worker's own emotional needs or conflicts have often obtruded into the relationship and thus the client's personality has been prostituted to serve these ego-centric elements of the worker's emotional life.

Both Christianity and psychotherapy are optimistic regarding the potentialities inherent in many human situations. They would probably agree that "the forces and resources within the life situation are to be trusted," that the solution of the problem is to be discovered or effected by the use of these rather than superimposing elements from outside the situation itself. The religionist may call these forces and

resources "divine grace," and the therapist "unconscious elements," but the practical reckoning with them is much the same. In this connection I think it is important that the effective worker within each discipline does not envision himself as "doing something for the client" but rather that he so structures the relationship and so makes the resources available that the client himself may experience growth, readjustment or self-acceptance and self-understanding.

Moreover there seems to be growing agreement that behavior has meaning if one but has the data to understand it. The dynamic view of personality and the concept of unconscious motivation have given new tools and new responsibilities. It is much easier piously to condemn behavior as sinful or to explain it simply by tagging it with a disease classification than to be willing humbly and painstakingly to *understand* it. Many find it extremely difficult to accept the full implications of unconscious dynamics within the personality. But those who possess considerable objectivity in this regard find that the hypothesis is a most serviceable one for them.

Disagreement

Principal disagreements seem to arise between the ideas of human responsibility and free will on the one hand, and that of a form of determinism on the other. The conflict seems to be more apparent than real when one comes to the level of actual human behavior. The objective and understanding Christian worker recognizes the limitations placed upon most individuals. Indeed he discovers that as more and more insight is gained the barriers are pushed back and the range of free will and individual responsibility much enlarged. It must be admitted frankly that many Christian clergy and laity still make easy judgments upon others and often upon themselves on the assumption of individual responsibility. But in this attitude they are by no means unique as witness our present legal and penal codes and the attitudes of many police and jurists.

A somewhat formidable bar to any complete agreement is the Christian concept of sin. This differs surprisingly among various schools of theology. There is, however, agreement among many religious leaders today that sin is not to be thought of so much as a series of specific acts, or infringements of God's rules as it is to be considered a disorientation of personality which shows itself in ego-centric attitudes and behavior. These of course prevent the individual growth toward that "wholeness" which is salvation. Since Christianity teaches that God has a will and a plan for man (at least in respect to the quality and richness of his life) those elements are sinful which cause "the race of man to depart from God" or His hopes for the race. The theologian believes that an honest recognition of the tragic failure of much of "human nature" will be salutary. So he preaches the "good news of sin" — that all men are a part to the failures of mankind and no one is unique in this respect.

But the other side of the shield is the teaching that man *as a child of God* has tremendous potentialities and urges him to greater self-acceptance and self-affirmation. In the best of Christianity man's tragic and sinful predicament is never presented without the accompanying assurance of means of forgiveness and God's desire to forgive the penitent. Unfortunately there are conservative branches of the Church which seem rather completely to neglect the deeper and more tragic elements of human life by pounding away at a list of "sins" which reflect a narrow moralism of certain religious bodies or social groups. This emphasis is not shared by many others who consider themselves as well qualified to speak for the Christian position.

In Christian teaching and practice much attention has been given to conscience. The principles of depth psychology at first sight undermine the view of a "still small voice" within the self, placed there by God as His representative to engage in the lists against the Tempter! As a matter of fact the moral theologian has always taught that the religious conscience must be informed by intelligence and that it must constantly be growing in wisdom and understanding. The rigid conscience which many pastors and confessors encounter is described in terms of "rigidity" and "specificity" which correspond rather closely to the description and observation of the Super-ego made in the literature of depth psychology. Many religionists have been greatly helped by the thinking of psychoanalysts regarding the origin and dynamics of the Super-ego. It would seem that informed workers in both religion and psychotherapy will have much in common as they seek to help clients gain more and more freedom in use of their intelligence and the more mature elements of personality.

Christianity unequivocally sets high standards for men. It contains a system of values. Value judgments are at least implicitly made upon individuals and society. The commonly mentioned difference between the therapist and the religious worker is that the former need not include values or value judgments in his work while the latter must always do so. The distinction is not clear cut. For whether he is consciously aware of the fact or not the psychiatric worker in the rapport situation is conveying some at least of his own values to his client. Complete emotional objectivity is not possible for any worker. Nor is it possible for him to divorce himself completely from a system of values or from implicit moral judgments. That the standards and values of Christianity are explicit may or may not be a handicap in its effect upon individuals. Most important is the question by whom and in what manner they are presented.

THE NATURE AND FUNCTION OF A CHURCH CLINIC

REV. HERMAN L. BARBERY
CLIFTON E. KEW

It is a known fact that religion and psychiatry are closely related, that each has as its goal the betterment of mankind. It is not equally known, however, that the methods of either religion or psychiatry can be more effective if used together in helping people solve their problems. This alliance between religion and psychiatry can achieve results which cannot be obtained if either is used alone.

This paper will present the salient features of an experiment begun twelve years ago when a psychiatric clinic[1] was set up in a church. The staff now consists of three ministers, three psychiatrists, two psychologists, and a social worker. The ministers arrange to see people on almost any day; the psychiatrists and psychologists volunteer their time and skill, and meet with the patients in the church rooms.

Any member of the staff may hold the initial interview; then the patient is referred to the staff member who will be most helpful in counseling and therapy. The patient may be referred to the psychologists for diagnostic tests. Appointments are made in advance so as not to keep the patients waiting. No charge is made for any service rendered, but a small gift to the church as a token of gratitude is not discouraged. Help is attempted for all who come.

Religion and Psychiatry Complementary

Religion and psychiatry do complement each other. They work together in undoing evil and promoting good. The church can have a definite and dynamic relationship to psychiatry; psychiatry can be a friend of religion.

We find repeated demonstrations of the validity and effectiveness of religion and psychiatry in cooperation. Given mutual understanding as to objectives, regard for the function and extent of each other's fields, and a desire to cooperate for the healing of sick souls, the leaders in both spheres can increase the measure of their effectiveness. Sick people are often in need of what both minister and psychiatrist can give — together.

[1] The clinic was begun by Smiley Blanton, M.D., and the Rev. Norman Vincent Peale, D.D., minister of Marble Collegiate Church. It is still supervised by Dr. Blanton.

All of the clinical illustrations used in this article bear this out, but those immediately following emphasize it.

CASE I

A young woman, twenty-two years of age, complained of frequent pain in the head which was so severe that she was unable to work at times. She thought it was the result of an injury received in a car accident. During the conversation with the minister, he found that there was some strain in her home relations. He also observed that she had a frequent twitch of the cheek and nervous demeanor which he suspected was symptomatic of an emotional disturbance. He suggested that she also see the clinical psychologist.

In her first interview with him it was found that her headaches were caused by internalized aggression rooted in her resentment against her mother and were not at all related to any injury she had received on her head. He allowed her to express her resentment against her friends, co-workers, and toward the people who were responsible for the accident. He pointed out that her problem was emotional, and he asked her to return the following week.

At the second interview she stated on entering the consultation room, "What do you know, I haven't had a headache all week!" He explained the dynamics of this and she experienced release from pain and guilt. She left surprised, released, and happy. She was encouraged to return if her headaches persisted, but nearly two years have passed and she has not appeared.

CASE II

A young woman interviewed by our psychiatrist for the first time showed symptoms of anxiety which expressed itself in bewilderment about the origin and destiny of the world, the problem of suffering, and the seeming meaninglessness of the individual in the vast scheme of the universe and in the course of historical events. She was of Jewish background but had not received much religious training in her own faith. Her feeling of insecurity about the universe presented an opportunity for the minister to show that the greatest mystery of the universe was not its vast star-strewn spaces but the human spirit that could see all this as the work of a creative and purposeful God; the human mind that could measure the distances between stars in light years, and that in Hebrew-Christian thought the most valuable object was the human soul. The psychiatrist reported that the patient improved after the interview.

The fact that a clinic is in a church assists a person in need to accept help from another person, minister or psychiatrist, and to rely upon some power greater than man which will release the creative forces that are within the individual himself. In the unconscious mind of many patients, religion solves the conflict of guilt and hostility which is at the root of many emotional problems by setting up an authority too loving to be hated and too great to be destroyed.

CASE III

A woman in her early thirties and an only child came to the clinic for help. Her problem in her own words was: "I've been afraid all my life, and I feel I need more faith. I have fear of life itself. I don't know why I'm here or what for. I don't like the idea of dying or of living forever . . . I think I should see a minister."

The interview revealed that she suffered from insomnia, anxiety, hopelessness, insecurity, inability to get along with people, and a tendency "to hold grudges and to get back at them." Behind her insecurity was a bitterness toward the world in general which she felt had rejected her. She appeared to have more faith in assistance from a minister; so she was referred to one for counseling.

He discovered that she had difficulty in meeting people and felt imposed upon by them in her work. Questions about her early years revealed that her "lack of faith" and insecurity coincided with the death of her father. When the void left through the removal of her father's love at an early age had not been adequately supplied from other human sources, she felt isolated and unwanted. The lack of love in her life, with its results, she interpreted later as a defect in her religion. Exploration of these factors, practical consideration of her work, and prayer were helpful to her.

Motivation for Coming

An important aspect of this type of clinic is the *motivation of the patients*. What are the ideas that prompt them to seek help? How does this motivation compare with that of patients in other clinics? How does it affect therapy and healing?

We find that the patients' motivation is largely related to a background of religious and ethical experience. A large number come from the major Protestant denominations. Many are regular church attendants who hesitate to present their problems to their own pastor or to a minister whom they know. Frequently, however, a minister will send a member to the clinic or will come with the parishioner. People seek help where there is a concentration of skill and effort upon the solution of personal problems combined with a sympathetic religious view of life.

It is likewise evident that people somewhat averse to stereotyped expressions of religion seek help in this clinic, because they feel that where religion and psychiatry unite in such a common effort, they will find an intelligent approach to problems combined with religious tolerance in which they may freely and frankly discuss their doubts and sins, frustrations, and fears. "No mumbo-jumbo for me," said one person. Even those who have been suspicious of psychiatry overcome their hesitation and seek help. The alleviation of this suspicion means hope and help for many who otherwise would continue to suffer, probably get worse, and perhaps develop severe emotional disorders.

We often hear such remarks as these: "I felt you would look at my problem from the religious angle." "I won't talk to a psychiatrist who

doesn't believe in religion." "I feel that religion should be considered when dealing with my problem." Said a young man from a university, "Your psychiatrists must be sympathetic toward religion." Another said, "I probably need some psychiatric help, but I did not want to pick out any psychiatrist in a directory."

Others come because they fear that if they sought help elsewhere, they might be sent to an institution for the mentally ill. A man (Case V) overcame the fear that "you would take one look at me and send me to a mental institution." Many express the feeling of coming to the clinic as a last resort. One said, "I did not know where to go or what to do; so I came here." A few expect "a miracle will happen."

Over a fourth of the patients suffer from depression, a feeling of helplessness, and despair. Nearly twenty per cent of them have marital difficulties. Sometimes the fact that "we were married here" or "once attended church here," prompts them to return for help. For a tabulation of problems see Table I.

A Church Clinic and Therapy

The church clinic accepts man as a religious being with a sense of values, to whom the religious and ethical life are normal; a being conscious of his limitations, prone to error, often resisting his own good, but reaching out to a higher Power for life fulfillment; a being who may be religiously or emotionally sick, but who has forces within him working for his recovery and who is able to assimilate help from human and divine sources beyond himself.

This recognition of the religious and ethical nature of personality by both psychiatrist and minister is an aid to therapy in that it diminishes the patient's destructive sense of futility, strengthens his feeling of worth, leads him to realize he is understood and accepted. Such an approach circumvents the psychological blocking which may arise if and when the patient becomes aware of a therapist's lack of sympathy with his religious or ethical approach to life.

This understanding on the part of the counselor need not imply intellectual agreement with the theological concepts which the patient may hold. The important point here is that the patient is understood and accepted as he is. Where the sick person breathes the atmosphere of love and works toward intelligent solutions, he begins to get well.

CASE IV

The person concerned was the victim of a neurosis which had confined her to psychiatric institutions several times in fifteen years. When sixteen years of age she collapsed in school, had a "nervous breakdown," and spent seven months in a hospital. But the treatment alleviated the condition only temporarily. She was not opposed to psychiatry; one psychiatrist in particular had given her encouragement. Her background and ideals were Christian.

Her marks in high school courses, which she completed, were consistently high. At the time of the first interview, she was thirty-one years old and the mother of two children; yet for the second time in eight years she felt her marriage disintegrating.

During her initial interview with the minister, she showed symptoms of strong anxiety, regression, personality changes, suicidal tendencies, bewilderment, resentment against her husband, and abnormal attitudes toward her second child whom she had rejected months before he was born.

While pregnant with this child, she would often become dizzy and be projected into some scene from the past. This image on the screen of her mind would blot out immediate experience. Panic would follow. She would never remember the scene afterward. From the time the child was born, the mother could hardly bear any physical contact with him.

She wrote: "I was emotionally unstable, unpredictable in my words and sudden personality changes, lacking in security, self-confidence and self-respect, anguished in mind and spirit, and torn by internal conflicts. I was so desperate for peace of mind that suicidal impulses frequently overwhelmed me, and I lost my faith in God and man."

The neurosis was seen to be rooted in her family background and environment which was marked by sexual perversions in other members of the family. These had created fear, had obstructed a wholesome view of marriage, and caused her to regard family groups with disgust because children were born as the result of intercourse between the sexes.

Release from tension and faith in the possibility of further help followed this interview. She wrote: "My first interview opened up a new and vital avenue of encouragement such as I had scarcely known before. On the basis of that faith which I had denied, you placed implicit belief in me as an individual and in God to effect a cure."

Biweekly interviews over a period of four months produced a series of religious experiences marked by elation and release from anxiety; though the unfavorable relationships with her husband at this time restricted their extent. Baptism and participation in the Lord's Supper were followed, she reported, "by a week of peace, security, acceptance, and a new consciousness of God as an abiding Presence that worked startling changes in me. This brought joy, amazement, and hope to my husband and children." But her feelings of shame and inferiority which were rooted in memories of her family made her unable to endure new social contacts, even within the church, where first attempts ended in frustration and a hurried retreat.

That it was an interpersonal problem soon became manifest. Recovery depended to some extent upon the cooperation of the husband whose behavior up to this time was marked by bewilderment, fear, conflict with his wife, and aversion to psychiatric help for her or for himself. But he was not opposed to the help of an understanding minister, and he was already appreciative of the help his wife had received.

Four months from the first interview marked a very low point in her condition. By now she was convinced that in order to get better she would have to leave her family. The minister held two interviews with the husband who went home and asked his wife's forgiveness. This was readily given, a new start was possible, and from that moment on improvement was rapid.

The therapy of preceding months worked its way out in remarkable mental changes; fears, resentment, and self-imposed guilt gave way to the acceptance of her husband and younger child who readily responded to the love received. Her doctor reported a marked improvement in her physical condition. There also resulted increase in efficiency in the home, interest in and love for both children, sound sleep and freedom in social life. Medical care has been continued and ten months later the family is united and happy.

A clinic in *a church setting* is itself an aid to therapy. There is within the consciousness of even the immaturely religious, the thought and feeling that the spiritual fellowship is the home of love, where he will find compassion for the unfortunate, help for the needy, forgiveness for the contrite. He is likely to associate it with comfort, stability, and renewal.

There can be many practical arrangements for dealing with personal problems. A minister may by increased interest and study, further his effectiveness in this field. Two or more ministers may organize a counseling plan. Again, with the cooperation of psychiatrists and psychologists a clinical ministry of this kind can be carried on at a chosen center. Where this is not possible, ministers, psychiatrists, and social workers could function in separate places in a town while having a working relationship, referring the patients to one another.

The Help of the Fellowship

While receiving help from a minister or psychiatrist in a church setting, many people recover because they also receive the creative strength of the many and varied personalities who compose the religious fellowship in which they now have an interest. They find others who are overcoming similar difficulties and who, though conscious of their own limitations, are working for a fuller life for themselves and others. In this atmosphere latent abilities and frustrated drives are released, controlled, and directed. Merging his life with the corporate life of the fellowship, the sick person is helped to become integrated and whole. He finds deeper interpersonal relationships which are a prime necessity for healthy and growing persons.

Within this creative fellowship the depressed person discovers the religious and social outlets and interests which he is so often told to get but fails to cultivate because he does not know where nor how. The patient is encouraged to obtain these social contacts and creative fellowship in the church of his own choice. The capacity for love grows when the opportunity is provided for its development.

CASE V

A man aged thirty-three came to the clinic in a very depressed and anxious state. He was separated from his wife and had been unemployed for several years. "For four years," he stated, "I have been this way, but I did not know where to go for help until I learned about this clinic."

Therapy was undertaken, and with a great deal of difficulty he related his childhood experiences. At the age of ten he was exposed to sex experiences and again at the age of fourteen he was seduced by a man. Due to this, he felt that he had sinned and that he would be punished. Up to the age of twenty-one he did not have much social life; he was working to support a family which an alcoholic father failed to do. He had ambivalent feelings toward his parents and guilt feelings toward himself which crippled his personality. Catharsis through counseling relieved his deeply-rooted guilt and anxiety which had been smouldering in his unconscious since childhood; and he gained insight into his problem. He identified strongly with his mother but hated her for his unconscious dependence upon her; on the other hand, his hostility for his father was a defence against intense unconscious love for him, coupled with the unkindness of his father toward his mother. He slowly gained confidence and hope, overcame his depression, anxiety, and sense of failure. He now writes: "All of this has given me an understanding of my parents which is developing into a love for them. . . . Christianity tells us to honor our father and mother, and psychology removes the blocks which prevent us from doing so. It is a great combination."

During therapy he was encouraged to attend the various group activities at the church. This he did at first very reluctantly as he felt, "I am not good enough." But group contacts soon provided the opportunity for him to obtain new relationships and the social life necessary for a growing person. Through his activity, he gained confidence in himself. The church employment committee assisted him in obtaining work. He had several interviews with the minister and finally joined the church, of which he is one of the most active and helpful members. He is now doing well. He writes: "I still have some barriers to overcome . . . but I have picked up the seeds of faith, hope, and love which I intend to nourish, for without them life is misery."

Summary and Conclusions

1. *Religion and psychiatry complement each other.* They work together in destroying the evil in man and promoting the good. The church has a definite and dynamic place in the psychiatric field.

2. *The motivation of these patients is different from other clinics.* The religio-psychiatric clinic is a powerful factor in motivating people to seek psychiatric help where ethical and religious values will not be overlooked.

3. *Help for those who would not otherwise get it.* Without this a great majority of those who attend the clinic would receive no psychiatric help. Many would suffer greatly without help or hope, and would develop into severe psychiatric cases.

4. *Prevention of further disturbances.* Such a clinic results in the prevention of further disturbances. Experience shows that the clinic attracts many people in the early manifestation of emotional disturbances. Therapy then serves to arrest the development of severe neuroses and psychoses.

5. *Religion aids in the acceptance of psychiatry.* Beneath the expressed desire of a person to see a minister, there is often a suppressed

desire to see a psychiatrist. The fact is discovered and the assurance and guidance of a minister often leads to an interview with one.

6. *The minister's skill is improved in dealing with troubled minds.* Ministers who are continually seeing numerous people of all ages can detect early emotional disturbances and give both practical counsel and supportive therapy.

7. *The church as a help to therapy.* A clinic having psychiatrists and psychologists who accept the basic teachings of the Bible strengthens the confidence of most of the patients in the therapist. Also the clinic's being in a church aids the transference and gives the patient a feeling of protectiveness, which diminishes the time needed for therapy and accelerates recovery. Having been accepted and given courage, the patient accepts therapy in such a setting; while the sense of belonging reduces the sense of guilt which characterizes so many of the anxious.

8. *Opportunity for the growing self.* Deeper interpersonal relationships are begun, expanded, and maintained. They reach the patient's life at a deeper level than that to which he is exposed in other clinics or to which he is accustomed in daily living among family, friends, and fellow workers. Besides this therapeutic relationship within the clinic, the church helps him to have the creative fellowship which he needs. He is provided a setting in which he can find resources to help himself.

TABLE I

DISTRIBUTION OF PATIENTS BY PROBLEM

FOR ONE-HALF CHURCH CALENDAR YEAR, 1947–1948

Problem	*Frequency*
Arteriosclerotic Changes	3
Involutional Melancholia	5
Alcoholism	5
Requesting Information	5
Obsessional and Compulsion Neurosis	5
Paranoid Features	10
Severe Anxiety, Anxiety Neurosis	13
Panic, Latent Schizophrenia, Schizoid, Schizophrenia	27
Marital Problems	29
Psychoneuroses and Miscellaneous	31
Neurotic Depression with Anxiety Features	43
	176

TABLE II

DISTRIBUTION OF PATIENTS BY AGE GROUP FOR ONE CHURCH CALENDAR YEAR, 1947–1948

Age in Years	*Frequency*
5– 9	1
10–14	3
15–19	4
20–24	30
25–29	44
30–34	52
35–39	43
40–44	38
45–49	27
50–54	33
55–59	17
60–64	18
65–69	12
70–74	3
75–79	1
80–84	0
85 and over	1
	327

TABLE III

COMPARISON OF SINGLE AND MARRIED PATIENTS BY AGE GROUP FOR ONE CHURCH CALENDAR YEAR 1947–1948

Age in Years	*Frequency*	
	Single	*Married*
5– 9	1	0
10–14	3	0
15–19	4	0
20–24	27	3
25–29	28	16
30–34	25	27
35–39	15	28
40–44	12	26
45–49	9	18
50–54	11	22
55–59	6	11
60–64	5	13
65–69	5	7
70–74	2	1
75–79	0	1
over 80	1	0
	154	173

A CHAPLAINCY PROGRAM IN THE GENERAL HOSPITAL

REV. JAMES H. BURNS

THE chaplaincy program in a large general hospital deserves thoughtful study. The ministry to the hospital community is basically the same as ministry to persons anywhere. However, the tempo and method of execution tends to be somewhat specialized. Further, to a degree not common in other institutions, the ministry to patients is not especially different from the ministry to the families of the patients, the hospital staff and their families, student groups and employees. The patients in general hospitals are for the most part mentally and emotionally functioning efficiently. They are usually still dynamically a member of their family, neighborhood and work group. Also, they are removed from their normal environment an average of only twelve days. Finally, illnesses which can be treated in a general hospital do not often draw social disapproval or ostracism and condemnation. Therefore, personally, dynamically, and socially the general hospital patient is very much like the persons who visit him or the people who take care of him. As a result the Protestant Chaplain of a general hospital is pastor of *all* the Protestant people who are in or come into the hospital. Such a ministry can rarely if ever be completely maintained, but it must be the goal and point of view of the general hospital chaplaincy program.

Several chaplains aiming at this kind of program have found that four hours per day of bedside calling is the maximum possible. During three or four hours of bedside calling the chaplain can hope to make about ten calls. Fortunately, during the day, the chaplain will meet several score, even a hundred or more people, and can speak to them in such a way that a pastoral relationship can be established and nurtured by these fleeting contacts. A Chaplain's Letter can be a vital link in the chain of a full ministry in a general hospital. It should be sent to all new Protestant patients, arriving usually on the second hospital day. The envelope should be sealed, with the patient's full name clearly written or typed on it and with the Chaplain's name and address in the usual return address area. The following is a sample which has been used for about three years. It has brought about a gratifying response.

Reprinted with permission from *The American Protestant Hospital Association Bulletin*, Vol. 14, No. 1, November, 1949.

Dear Friend:

Although your illness has temporarily removed you from home and friends, such reminders as letters, cards and personal calls show that you are not forgotten.

This letter serves a similar purpose. Regardless of your relationship to the Church, we want you to know that it stands ready to assist in every possible way. If you feel the need for spiritual support or perhaps merely a friendly call, ask your nurse to telephone our office (Extension 825) or to notify the Information Desk.

Faithfully yours,
(*Signature*)
Protestant Chaplain*

*Representing the Massachusetts Council of Churches

The luncheon period is another fruitful time for establishing and strengthening pastoral relationships. Doctors, nurses, social workers, technicians, clerks, secretaries, students, relatives of patients, and former patients usually can be found in the cafeteria if they are in the hospital at the noon hour. The chaplain may judiciously make luncheon appointments or deliberately select his table mates. In ministering to the whole hospital community, the chaplain will need to plan for time to see people privately on appointment or without appointment when they seek him out for counsel. However, he can no more carry a heavy counseling load than can the parish clergyman. At any given time, the general hospital chaplain may be seeing *only* one or two persons for extensive counseling on a regular weekly or bi-weekly basis, no more! Student assistants and certain volunteers such as Lady Visitors, Gray Ladies, and women from denominational groups are of value in direct proportion to their dedication, training, and experience. The chaplain has failed in his job if he becomes entirely an administrator and spends his time supervising ministerial and non-ministerial assistants and does no pastoral work himself.

Another phase of the chaplaincy program in a large general hospital is the teaching. The most important teaching job of the chaplain is the clinical pastoral training of seminarians and parish clergy. There are three separate but related types of clinical pastoral training. The most common is the Summer School, either six or twelve weeks in length. Usually a Summer School of Pastoral Care offers both a well-rounded introduction to the dynamics of human behavior, or interpersonal relations, and of interprofessional cooperation and a program of strong informational and methodological orientation. The second kind of training is carried on in conjunction with a nearby seminary or theological college. As a part of an academic course, the students come to the hospital for a half day or more each week for supervised calling on the sick. The third and much less common program is made possible by awarding one or two fellowships to men who spend a calendar year in full time training in a single hospital under the chaplain's supervision.

Other teaching may be done by the chaplain in a general hospital. He may be a regular lecturer in the School of Nursing where he deals in a practical way with matters of ethics and morals, as well as with religious and psychological subjects. He is naturally the spiritual advisor of the religious organization of the Protestant nurses. This is a combination role and is only partly a teaching relationship. Because nearly all large general hospitals are teaching hospitals the Protestant Chaplain tends to be called upon to interpret the religious work in the hospital to the various student groups.

To turn to the stone upon which many chaplaincy programs have broken up, it can be said confidently that the unsolved problem for the chaplaincy program in the general hospital is the financing. Since all general hospitals have for years had large annual deficits, support for many established chaplaincies has been withdrawn and it is rare to phenomenal in these days for the trustees of a general non-sectarian hospital to underwrite the salaries of *three* chaplains to represent the three major faiths. Nevertheless, it appears that at least token financial support should come from the hospital. The most obvious reason for this is that as long as the chaplain is not paid anything by the hospital where he works he is considered a "guest" in the hospital with easily withdrawable privileges and no clearly defined responsibilities. On the other hand, full support from the hospital is equally undesirable, for under this circumstance the hospital administrator, the hospital trustees, the chairman of the medical or psychiatric staff, the head of social service, the principal of the nursing school or some other non-ministerial professional person may be assigned the task of defining what the chaplain's duties are. When this happens, the chaplaincy program soon breaks down. Also, support from a trust or foundation is tempting but highly unsatisfactory for it usually is temporary and gradually withdrawn. A few city and state councils of churches have found that inclusion of part of the chaplain's salary in their budgets has made their drive for funds much more understandable to the citizens of the community. Earlier, the chaplain's teaching was mentioned. On the basis of services rendered, the seminaries using the chaplain in their clinical pastoral training program should assume a just portion of the salary load. For the sake of concreteness, it is suggested that the general hospital ought to furnish an office for the chaplains and about one quarter of their salaries (*i.e.*, a minimum of $1,000.00 per annum per chaplain); the council of churches ought to supply approximately one half the Protestant chaplain's salary (this could be raised from the community and from the denominations as a part of their Home Missions opportunity); and the remaining portion of the chaplain's salary should come from the seminaries.

A little must be said about who should sponsor the chaplaincy program in the general hospital and be the policy-forming agent. This agency should provide general supervision of the chaplaincy program, otherwise as has already been suggested, if the hospital pays the bill,

supervision will be assigned to or will be assumed by someone in authority in the hospital. The program should be sponsored by an adequate ecclesiastical authority, which is the final source of policy to which the chaplain is responsible, to which he makes reports, and to which he turns for counsel, guidance, and backing. Of course, the chaplain should also make regular reports to the administrator of the hospital and will consult him regularly on matters concerning internal administrative procedures. The ecclesiastical authority, which may be a national organization of a denomination (or a department of it), the state organization of a denomination, a strong urban church, a state council of churches, or a city council of churches, should be the policy-making body for the chaplaincy program and the channel through which the chaplain may present his work to a Protestant constituency.

To summarize briefly: First, the Protestant Chaplaincy program in a general hospital must have as its goal, ministry to *all* Protestants who are in or come into the hospital. Second, the program must include clinical pastoral training for seminarians and parish clergy as a major responsibility of the chaplain. Third, the chaplaincy program ought to be underwritten by the hospital, the sponsoring ecclesiastical authority, and the seminaries. Fourth, policy and supervision should be administered by the sponsoring ecclesiastical authority.

THE PHYSICIAN-PATIENT RELATIONSHIP

ALLEN S. JOHNSON, M.D.

THE progress of cerebral localization which began very modestly in the nineteenth century with the identification of various motor areas in the brain has now progressed to a point where pathological emotional patterns may be permanently altered by disconnecting or removing certain integrating pathways in the higher centers. At the present rate some enterprising neurologist may soon announce that he has identified the locus of the soul. Pending that time, it is a useful concept, quite apart from its ecclesiastical connotation, for integrating the emotional and intellectual patterns of the individual with the mores of his environment. And it is in this sphere that the clergyman can be of greatest help to the physician.

The influence of the emotions on disease has been recognized for a long time; but the recent increase in disorders resulting from environmental stress, rather than from infection, injury, or metabolic derangement, has given rise to the term "psychosomatic disorder." The psychosomatic approach can be of great value, but it must not be worked to death. To the extent that it leads to a better appreciation of the role of emotion in disease, it is useful, but if it gives rise to a careless discipline whereby every disorder for which no cause is immediately apparent is called psychosomatic, it can do much harm. It is deceptively simple to conclude that the emotional concomitants of a poorly understood entity, such as peptic ulcer, are the *cause* of the disorder, when they may be largely the *result* of the persistently distressing symptoms. Certainly an inexorably recurrent belly-ache can spoil the *joie de vivre* of the most confirmed optimist! More dangerous is the temptation to attribute the vague symptoms of a confirmed neurotic to his inadequate personality. A long history of psychological inadequacy does not protect the patient against any or all of the ills from which a psychologically more robust person is entitled to suffer. A constant complainer is a perpetual source of anxiety to the conscientious physician who always wonders if the nervous indigestion this month is due to an early cancer of the stomach instead of to the emotional stress from which the patient is known to have suffered for the past decade. We "middle-of-the-roaders" are trying to steer a common-sense course between the mechanists, sitting

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granite-like on one curb, and the Freudians in the opposite gutter. Let us give emotion, like the Devil, its due, but let us not make it the scapegoat for every baffling illness.

Most doctors are constantly importuned for tonics supposed to "build one up" when he is "run down", although the patient usually has no clear idea of what he means by these terms beyond the fact that he'd like to feel better than he does at that moment with a minimum of effort on his own part. Careful investigation generally reveals that what the patient needs is the alleviation of worry, surcease from sorrow, the revival of hope. Personally, I am almost convinced that the only tonic that is psychologically sound and physiologically effective is hope. And this is where the clergy, with their tact and sympathy and knowledge of the human heart can help doctors to do a better job.

Hope reminds one a little of the inflation which some economists think is a good thing in small amounts and if properly controlled. Certainly it is both dishonest and unkind to raise false hopes, however stimulating they may be temporarily, for there is always the "morning-after" of disillusionment. Often we have to rest content with trying to inculcate in the patient simply a philosophy of optimistic fatalism. Certainly the only hope which will bring the patient lasting benefit is the hope based on truth. We shall not enter here into a philosophical or theological discussion of the nature of hope and truth. For the physician's purposes, truth rests on objective data acceptable to those trained in their evaluation and distorted to a minimum by emotional bias and wishful thinking. In medicine it is a relative quantity and must be viewed with reservations for the same reason that the terms "always" and "never" are anathema to the honest physician. For example, we know that certain shadows in a chest X-ray mean pulmonary tuberculosis in such a high percentage of cases that to refuse to abide by this distasteful diagnosis may mean sacrificing the chance of early recovery, and perhaps the chance of any recovery. If in addition to the X-ray findings we find tubercule bacilli in the sputum, it makes the diagnosis all the more probable and appropriate treatment correspondingly imperative. It is not an absolute truth — if such there be — but it offers such an overwhelming probability that only the veriest chump would ignore it for that infinitely remote chance that the diagnosis was wrong.

A famous Boston clinician who became a philosopher of sorts in his later years used to insist that the patient was entitled to know the truth. We must individualize here, for the truth can be strangely warped in its presentation, and, what is not so well recognized, in the manner of its acceptance. White lies may be justified but they are usually a tribute to the compassion rather than to the ingenuity of the manufacturer. Certainly it is unwise to lie if there is any risk of getting caught, and who can presume to evaluate that risk? The four questions which we are most often asked are: *Is it serious? Is the operation dangerous? Will I get well? Am I going to die?*

Before we can answer the first question, we must be sure that the word "serious" has the same connotation for both doctor and patient. To some patients an illness is serious if he has to stay in bed or decrease his consumption of alcohol. To others a threat to life is implied in the term. Rather than to say whether it is or is not serious, it is preferable to present the probabilities of the results of various courses of action. "You have a temperature of 102 and a bad head cold. If you go to bed and do as you are told the chances are exceedingly good that you will get over it in a few days. If you refuse, and particularly if you insist on going out to work you will certainly prolong your illness needlessly and run a very real risk of pneumonia." In another case we might say, "Yes, your husband has pneumonia but we are fortunate today in having treatment which has reduced the mortality from 30% to 5%." Or, "Your husband has had a coronary thrombosis. We know that this is the most important cause of death among his age group today but we also know that the majority of these cases recover and that 50% of them return to their former occupation, provided that they play their part in assisting nature in recovery." I believe that it is important to present the future in as optimistic a light as possible, but to make it contingent upon the cooperation and good faith of the patient. This philosophy is at variance with that of the doctor who always stresses the seriousness of the situation; the latter is sometimes, unfortunately, part of a subtle strategy designed to enhance the doctor's prestige. If the patient does as badly as the doctor has predicted, the family cannot complain that he didn't "give it to them straight from the shoulder" and certainly they can hardly blame him for losing such a desperately ill patient. If, on the other hand, the patient confounds one and all by recovering, all this merely redounds to the doctor's credit, for he has now pulled a desperately sick patient through a mortal illness. The intellectual honesty of the physician is put to a great strain in such a situation, where the doctor benefits at the expense of the household's, and particularly the patient's, peace of mind, and some are unable to resist the temptation.

Is the operation dangerous? At the risk of seeming to ignore the preceding counsel of studied optimism, I always answer "Yes," but with the following qualification: there is an inevitable statistical risk connected with any operation, however trifling, and for that reason none should be undertaken light-heartedly. A well trained and experienced operating team supplied with the material advantages of modern science can greatly reduce that risk but it is still there. That the mortality of the last consecutive thousand such cases was only 0.1% is cold comfort if that one fatality was a loved one. Yes, any operation is dangerous to some degree; but we must weigh the benefits to be obtained from an elective procedure against the known statistical risk. A vigorous, sports-loving male of 34 might well prefer the statistical risk of repairing his hernia to the nuisance of wearing a truss for the next 34 years. On the other hand, a man of 65, with a life expectancy of only 12 years, might

well hesitate to accept the operative risk, which has now tripled at this age, even when the patient is in good physical condition.

When the condition for which surgery is contemplated threatens the patient's life, it is hardly an elective procedure, but we must still try to balance the risks. This time we must consider the risk of the operation against the risk of neglecting the condition. An appendectomy carries a certain mortality, but it is low if the appendix has not ruptured, and it is much less than the mortality from peritonitis which may develop if the appendix does rupture because the patient refused to accept the risk of early operation. The operation for cancer of the rectum carries a high mortality but also a real chance of cure if the patient survives the operation. Death is ghastly and inexorable if operation is refused. But these are over-simplified examples, and decisions are not always so clear-cut. It is sometimes difficult for the surgeon to decide in the case of a desperately ill and perhaps neglected patient whether an operation will save him or only hasten his demise. Here again intellectual honesty is a jewel beyond price. An unscrupulous surgeon who specializes in removing normal organs for trifling cause and eschewing operations on seriously ill patients who really need them may easily gain an enviable reputation for low operative mortality. In evaluating the risk, a variety of technical considerations is involved, but there remains an intangible that smacks of necromancy. Occasionally a patient accepts a non-elective operation but announces resignedly that he knows he won't survive, and he's usually right. This must not be confused with the self-centered exhibitionism of the neurotic who is fishing for attention and reassurance. But when this reaction is found in a rational, emotionally stable adult it is a most unhappy augury. The moral of all this is: Never try to sell a patient an operation.

Will I get well? the patient asks not infrequently, meaning not will he survive but will he recover completely. When ultimate recovery is assured beyond a reasonable doubt this presents no problem. But it is not easy to know how best to tell an adolescent that infantile paralysis or rheumatic fever has left an irreversible disability. I usually try to explain that we are not all equal in our endowments any more than our ears are all the same shape or that our feet the same size. As we grow older this discrepancy between the capabilities of different individuals grows more marked and we learn to capitalize on such assets as we have rather than to bewail our liabilities. The pundits would call this the philosophy of compensation, but it is really practical common-sense and the handicapped person must be helped to effect this compensation, which requires a rededication of the spirit as well as of the flesh. The purely physical rehabilitation can be handled by physicians, physiotherapists, and so forth. The emotional rehabilitation involved in overcoming disappointment and wounded pride requires the intelligent cooperation of all of us. Nothing is worse than the maudlin sentiment and saccharine sympathy that give the victim no practical philosophy on which to rebuild his hopes. The medical profession can often show

him *how* to effect this readjustment but it may take the clergyman to make him *want* to do so.

The same principles apply in the case of chronic disease. Often there are periods when the patient needs no active medical treatment but is sorely in need of sympathy and to be persuaded that life is still worthwhile despite his handicaps. At these times the clergyman can offer the much-needed emotional support by convincing the patient that he is not a forgotten bit of wreckage.

Am I going to die? is the least frequent question but the most difficult to answer. In view of the preceding comments we can limit our consideration to the patient whom we know is going to die of his illness in the immediate future. Of course, in many disorders we can only fear the worst and can make no definite predictions beyond telling the family that his expectation of life will inevitably be shortened. But all of us have been so badly mistaken in this type of case that we have learned to be very cautious in what we tell the family and particularly the patient. Certainly my own philosophy is one of cautious optimism. I tell the patient that I am sure that he would not be accepted for life insurance because insurance companies would lose money if they accepted everyone with his disorder. They know the odds on ten thousand such cases but I have to bet on his particular chance of survival, which is very difficult because a good deal depends on the effort he is willing to make on his own behalf.

We cannot be quite so evasive in the case of the patient who has microscopically proven cancer with metastases. Survival time can often be estimated in terms of weeks or months. The patient certainly has a right to be given a truthful answer if he asks for it. Not infrequently matters of vast importance to his dependents and heirs must be decided while he is still in possession of his faculties. Oddly enough, in my experience, the patient has not very often asked this specific question, although it is often implied. If he knows that cancer was found by the surgeon he usually knows when the operation turns out to have been in vain and makes his plans accordingly. His usual question after the operation is, "What did you find?" and if you tell him "Cancer," then "Could it all be removed?" Sometimes you can honestly say, "I think we got it all." But even when there are metastases to show that the growth was no longer limited to the primary site, the blow can be softened by saying, "We are going to give you some X-ray treatment to take care of the part of the growth that couldn't be removed."

People vary greatly in their reaction to the prospect of imminent demise. I have always felt that a man must be endowed with considerable mental and physical vigor to face with equanimity the uncertainties of the next world. Certainly there is a striking contrast between the death of a young soldier in battle and the querulous tenacity with which a chronic invalid clings to a futile vegetative existence. Occasionally a patient commits suicide, although this is usually provoked by

the prospect of prolonged suffering rather than by the fear of death. For others, under this shadow, life seems to take on richer meaning and a peculiar significance. One of these fortunates was Dr. Hans Zinsser, who wrote an autobiography, *As I Remember Him*, unique in many respects, not the least of which are the descriptions of his own birth and death.

It is when a man's days are truly numbered that the clergyman can offer the greatest comfort. The alleviation of physical suffering is still the function of the physician and he can do much to allay anxiety, but real spiritual comfort is the peculiar province of the church. To the patient devoted to ecclesiastical dogma and the ritual, the reenactment of these rites takes on particular significance and brings great peace of mind. To another a chance word or a certain turn of phrase may bring more comfort than the greatest efforts of the philosophers. These are the times when it is better to know the human heart than the wisdom of the ages.

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A STUDENT EVALUATION OF CLINICAL TRAINING

ROBERT H. CHALLINOR

THE importance of clinical training is becoming more and more widely recognized, and it has been incorporated into the curricula of many theological schools within recent years. Last summer I was privileged to attend a twelve-week course in clinical pastoral training for theological students, sponsored by the Council for Clinical Training. The summer session is conducted in approximately twenty-five institutions, mental hospitals, general hospitals, and penal and correctional institutions, all east of Iowa.

The program has many aims; to me the most important were those enabling us to gain a clearer understanding of the sick and afflicted, their deeper motivations and questions, their feelings and religious problems, their weaknesses and capacity for endurance under strain and stress. We developed ideas as to the methods for working with troubled people, and learned through practical experience many facets of our role as future clergymen. We realized our opportunities, our great responsibilities, and also our limitations.

The class this past summer was composed of eleven theological students, two ordained ministers, and three supervisors. Soon after our arrival we were supplied with white jackets and the title of Chaplain Internes, and then sent out to meet one of the largest general hospitals in the country — Bellevue.

To those who have been at Bellevue the very name stirs the emotions and brings up memories and images, not so much of the dull brick buildings, the smoke and soot, or block-long hospital wings that hover along the side of the East River in mid-town New York, but of pain, drama, tragedy, comedy, and refuge all in tune with the pulse of that monstrous city, New York. Bellevue is not the buildings — it is the people, coming in a continuous flow in automobiles, taxis, buses, ambulances; old and young, blind and lame, pregnant women, children laughing and crying; humanity with broken bones, diseased lungs, infections and bruises: these are the people whom we were privileged to know and serve.

What Bellevue is cannot be completely enumerated. It is a prison, a court of justice, a shelter, a morticians' school, an experiment in interreligious fellowship in which Roman Catholic priests, Jewish rabbis and Protestant chaplains hold their religious services in three chapels side by side. It is a technical school, a research laboratory, a refuge for the homeless and aged. It is an ex-bartenders' home, a half-way house

to the sanatoria in which consumptive bums, who usually sleep on park benches or the sidewalks of the Bowery, take shelter for the cold winter.

Bellevue is so immense that its nurses, internes, social workers, and even the chaplains get discouraged because there are so many people who need their skill and help. It seems futile to mend these people and then have to let them return to the polluted surroundings that bred their ailments. One cannot help but be bewildered and apprehensive. But day by day, year after year, Bellevue continues its unending job of repairing and restoring both soul and body.

But to return to the clinical training we received in this wonderful institution. We had seminars, lectures, tours, discussions, demonstrations and actual hospital calling. The seminars included lectures by staff physicians on the anatomical systems, their proper functions, breakdowns, diseases, and the techniques of mending and healing them. There were discussions and lectures on the proper way to make sick calls and to counsel the afflicted. Chaplain Otis Rice of St. Luke's Hospital gave a series of lectures on the emotional life of the individual, counseling the ill, marriage counseling and the use of psychology and psychiatry in counseling. We had opportunities to meet and talk with the supervisors of the General Hospital and the Psychiatric Hospital, the heads of the social service department, the department of nurses, the director of St. Barnabas House, and the director of the New York Protestant Episcopal City Mission Society, of which the chaplaincy at Bellevue is just a part.

The resident chaplains and our supervisors led discussions on counseling, confession, penance, grief, death, baptism and the use of social agencies in the hospital and in typical parish life. We studied case histories, the verbatim reports of previous chaplain internes, chaplains, and social workers. Through discussion of these cases we learned many techniques and some of the pitfalls to avoid in visiting the sick.

A resident psychiatrist gave lectures on the symptoms and signs of mental disturbances and breakdowns, and warned us repeatedly that we had not been trained in psychiatry, but were only learning the symptoms of mental illness. She explained that our job as clergymen is to direct those having the symptoms to the proper agencies, doctors, or institutions equipped to handle this type of illness.

Our mornings were given over to lectures, discussions and study. In the afternoons we were free to do our ward calling. It is a fearful yet exciting experience calling on different individuals from bed to bed, strangers when you meet them; friends, in many cases, when you leave. When we began our calling, we made initial visits. We received cards for each newly admitted Protestant patient. We would select cards according to different categories: age, sex, occupation, color, disease or illness. Then we would go to the patients we had selected and ask if we could minister to them in any way. Our first visits were to establish rapport;

some patients would welcome us, others were indifferent. Some were helped; others were not.

We learned through our discussions and lectures that we were to be "pin-cushions," that is, to let people stick pins in us and never pull them out or retaliate in any way. We were to take the patients' hostility, complaints, cursings, and not to make any apologies for the doctors, nurses, food, ward-help, or ourselves. We soon learned that when patients would release their hostility on us and open up to us and trust us, we could be of some help to them. We found that in many cases they feared the hospital staff, but usually they put a great deal of trust and faith in the chaplains.

We were required to make verbatim reports of our visits and then go over them with out supervisors. They in turn would ask us embarrassing questions, such as: "Why did you do this?" "Why did you say that?" "Why did you withdraw from this situation?" "Why did you change the subject here or there?" Through this process we learned a great deal about ourselves, our own motives and inhibitions, and were enabled to do better work with our supervisors' able assistance.

We each had to preach in the Psychiatric Hospital and the General Hospital. Preaching in the Psychiatric Hospital was almost as bad as preaching to a homiletics class in seminary, with the blank expressions and unresponsive faces. An hour later I had quite a different experience in preaching to a congregation of patients from the General Hospital. Accustomed to the rather restrained Episcopal service, I was startled when during my sermon some members of the congregation broke out into "Halleujah!" "Amen!" "Bless the Lord!" (clapping their hands). I nearly forgot the remainder of my sermon, but regained my composure and finished in a flourish, knowing that at least some of the congregation were still listening!

As Chaplain Internes we each had two tours of twenty-four hour duty when we were the only representatives of the Chaplain's Office. While on duty we had to visit all persons who were scheduled for operations the following day and be on call all night for any emergency that might arise. Many a time my knees were knocking when I realized that in that vast hospital *I* represented the Christian Church to those people who were calling to me for help in time of emotional and physical need. I learned more and more of the people's need and desire for prayer, for forgiveness and absolution. While on my nights of duty I had my first baptism (in an emergency situation) and several deaths, besides emergencies of stabbings and identification of persons whose religion was not known.

All of these vital experiences helped us to know and understand the needs and problems of the people whom we will serve in our ministries, and incidentally, to learn a great deal about ourselves. I firmly believe that clinical pastoral training, especially that offered in the general hospitals, should be sought by every theological student who wishes to be a minister in the Church of God—a *real* minister and pastor to his people.

PEDIATRICS AND THE CHURCH: A SYMPOSIUM

I. MILTON I. LEVINE, M.D.
II. PROF. REUEL L. HOWE

I

It seems to me natural and logical that the churches should be interested in the development of the young child and what pediatrics, as a special branch of medicine, has discovered about this. All of our more recent knowledge about child development emphasizes the importance of the first six years in the child's life as laying the fundamental basis upon which people later may or may not become good citizens, good human beings and good church members. The belief in the importance of the early years of life is by no means new. What is new is the increasingly significant documentation and corroboration of this as a fact.

The more we have studied children, the more we have come to see that an understanding of them means first an understanding of their most basic needs. Nothing that has emerged is nearly as important as this: That a child have the knowledge that he is truly loved and wanted by his parents and that he have a home in which his parents love each other and communicate that feeling to the child. One thing which pediatrics is doing increasingly is to document the implications of a statement like this even during the first year of a child's life.

Before birth the child is completely protected within the body of his mother. In spite of some fanciful theories we do not believe today that the actual experience of birth ordinarily produces any serious emotional difficulties in the child. Immediately after birth the child is a somewhat uncoordinated bunch of nerves. Emotionally the child is not functioning and does not have recognition or memory as yet. Recently we have learned that the very young child has practically no vision, something which was not known before. Facts of this kind are very important and can be discovered only by long and careful investigation.

We are just emerging from a period in which many people and even physicians thought that the main thing needed by a young baby was good physical care and therefore a nurse could do as good a job as the mother. We know today this is not true. A very young baby has a tremendous

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need for cuddling and love from his parents. Even the sound of his mother's voice is soothing to the baby. Interesting confirmation of this is found in the study by Dr. Lauretta Bender of children who were institutionalized in the first year and therefore did not have care by a mother. Even when grown up the behavior of most of these children is characterized by emotional instability, temper tantrums, inability to make friendships or to identify themselves with other people. They are frequently cruel, with an absence of anxiety and guilt. This seems to be because they have not learned how to identify with other people and have never experienced identification during the earliest period of life. If a young baby is taken care of by a dozen different persons with no continuity, it is impossible for him to learn how to identify and feel the security which comes from such identification. For the young child father and mother are gods and this fact lays a serious obligation for parents in their dealing with children especially in the earliest years of a child's life. Even psychotherapy can only modify a condition which is produced in those early years and cannot bring back completely what the child missed in the earliest years.

Because so much of a child's time and attention in the earliest days are given to feeding this is especially important in understanding the baby. The way in which a child's feeding is treated conditions his whole attitude toward his mother and others in later life. In the recent past it was the custom for the doctor to lay down careful formulas and schedules and many mothers treated this literally and legalistically. We now know that doing this tends to eliminate the mutuality which is absolutely essential between the mother and the child. Not only do babies differ among themselves, but each baby differs from day to day. The goal of pediatrics now is to have the baby completely relaxed about his feeding during his first year. This means no strict schedule is imposed, but the child is allowed to find his own schedule which he almost always does. Another way to say this is, "We consider it impossible to spoil a child during his first year." If we do this, we have learned that such children later on are much easier for parents to handle and educate.

After the child begins to toddle around a whole new world is opened to him. We must beware of thinking of him as a little adult which he is not. Almost the only basic need which we have to pay much attention to is for security and affection. Next the child begins to learn and experiment. He drops a ball, it bounces and parents encourage him. He drops a glass and this too teaches him something, but all too often he merely gets scolded about it and yet he is following out an essential need to experiment and find out more about the meaning and texture and significance of the world about him.

We have learned some important things about authority and discipline in relation to children. It is clear that discipline with a child is necessary. To live on impulse obviously would not work. But the capacity of a child to take reasonable and necessary discipline seems to be

directly dependent upon the love and security which he has and upon the freedom which is given him to experiment in his early days without basic danger to himself and other people. If these basic needs, instead of being channeled are merely frustrated and thwarted, we do know that children respond with aggression, but when that happens what the child needs is not authority as something imposed from the top, but an assurance that he can have these basic needs met. Dicipline and authority therefore have to do with reasonableness and consistency and not from something arbitrary from the child's point of view. If a child wants to continue play instead of taking his bath he can be told he will have a few minutes and then can be placed in the tub. This experience is very different from the child's point of view from simply yelling at him, taking the screaming child from his play and plunking him in the bath tub. The one act indicates a feeling of respect for him while the other does not.

We do well to remember also that the basic attitudes toward sex are developed in very early life especially in relation to feeding and toilet training. Little babies have a tremendous need for sucking. If parents recognize this and realize that meeting this need is important over and above the importance of getting food, then the child will get its satisfaction. Children who later on suck their thumbs are always those who have not had this need adequately satisfied in babyhood. If in toilet training the child gets the idea that all of this is dirty, he is too young to separate the excretory system from the genitals, and comes to believe that this whole area of his body is dirty, this can have an important influence upon sex attitudes in later life.

One other important paragraph of program for recent development in which I know the churches are very active is week day as well as Sunday nursery schools. The nursery school is a very important institution for the child at least from age three. Before that time the attention of the child is focused chiefly on relationships with his parents. He does not have a very deep need for companionship with other children of his own age. But from this point on it is very important that he have such contact. The essence of the processes going on is one of a socialized move from playing by himself or merely watching other children, to cooperative relationships in play with them. A good nursery school of course pays good attention to the personal needs of each individual child. The young child gets what he needs from the nursery school in half a day and an entire day separated from his mother may emotionally be too much for him, but good nursery school experience is very important in enlarging the child.

In these brief comments there has been time only to deal sketchily with the findings of pediatrics as related to the child up to the age of six. As a matter of fact we have studied more and know more about the needs and problems of children up to this period than we have those of the next period of development from age six to about age twelve. That period also is important and yet in a very real sense it merely builds upon the

child's experiences of the first six years and justifies us in calling this first period the most crucial of all. It seems to me that the increased knowledge which we are getting about child development can be very important to the work of the churches.

II

PERHAPS the most striking point in Dr. Levine's comments has been his emphasis on the significance of the first six years in the life of the child. That brings us up short, for it seems to me undeniable that most of our concern with the Christian education of children almost entirely ignores these first six years. We have tended to believe entirely too much that Christian education begins only when the child is able to deal with words and concepts. The full implications for Christian education therefore, of what the pediatricians are telling us, are very far reaching.

If we stop and question seriously what Christianity can possibly mean to young children we get something which is different from words and concepts. We get something which while not easy to define has to do with the relationship in the earliest days of the child's life. This relationship is almost entirely one between parent and child, symbolically it is very much wider than that. God has created people to live not in isolation, but in relationship. A person becomes a human being only in relationship. As Dr. Bender's study pointed out, children who are not raised by parents who give this kind of helpful relationship have all kinds of distortions in their attitudes and values which also are the distortions which keep them away from the basic attitudes and values for which Christian faith stands.

God creates man to live in relationship. This creative principle we see is fundamentally similar to the redemptive principle which is also the work of God. Man's sickness and his sin are born out of relationship, one kind of relationship, while his salvation and redemption are born out of relationship, a different kind of relationship. Christians believe that Christ, who was Jesus of Nazareth, initiated the redemptive dynamic and therefore gave us the clue to the redemptive relationship. It was necessary for the Christ to be made human, concrete and historical in order that he might enter into this complex of relationship which can produce health or sickness, holiness or sin.

The pediatrician is concerned about the quality of relationship which exists between parent and child. The Christian is concerned about this also, but he is also concerned with the means for redemption of the child from wrong relationship. If the first years are as important as we believe, and if the redemption of the child depends first and basically upon his relationship with his parents, then the role of the parents becomes something not peripheral or accidental, but basic in our thinking. This is true not only for the human welfare of the child, but also from the point of view the child will eventually have toward ultimate and eternal truth.

If eating in the early days has the significance which Dr. Levine ascribes to it, we must realize that this is also important from the standpoint of Christian education. We learn to love by being loved. The child's first experience of being loved is in being fed which is the beginning of the common association between eating and agape. Our Lord gave us the ultimate expression of the food-fellowship experience in the Sacrament of the Holy Communion. It is fair to suggest that the early experiences of the child with feeding and weaning strongly affect his later ability to enter into such experiences as the Holy Communion. It may be granted that we do not have conclusive evidence to prove this connection, but my own pastoral work has again and again brought out such a connection. It seems to me that questions like these are worthy of more serious study and research than we have had on them so far.

Understanding and dealing with hostility and aggression in young children is of great importance not only to the pediatrician, but to the theologian as well. If the child receives basic love and affection an occasional breakdown of this will do no harm as pediatricians confirm. But if the basic love is not present, we may find developing patterns of suspicion, despondency, aggressiveness or the like. People who have never received cannot see that it is more blessed to give than to receive. Such people not only have trouble in relations with other persons, but have no way of making sense out of religion. Religion for them will soon fall into an unhealthy pattern. In contrast, the child who is brought up in the way Dr. Levine suggested and who has basic love and respect in relation with his parents can some day say, "I believe in God", and have that be one expression of his capacity to be related to the world in which he lives. When a child needs love most, it is frequently most difficult for the parent to give it. In fact it is to be doubted whether under such circumstances a parent can give it unless he has a real understanding of what is involved.

Dr. Levine pointed out that the parents are the first God to the child. Since the attitude which the child gets toward his parents is therefore the prototype of his attitude toward God, it becomes profoundly important from the point of view of the church. What Dr. Levine has said seems to take on new meaning in the light of this fact.

The child needs the experience of obeying an authority who sets limits to his experience. Without this he feels panicky and insecure, but it is vitally important that this authority be healthy and reasonable. The general problem which is involved here concerns the relation between limitation and freedom. Within the limitations of the law man is free. The theologian believes that these things have to be kept in balance. No matter how fine the child and parent there are bound to be conflicts which arouse aggressive and hostile feelings. If the parents can understand and therefore accept the hostility of the child, we have not only good child development, but good Christian education. If they cannot, we have poor child development and poor Christian education. The

parent is bound in some respects to be intolerable to the child and therefore threatens the child. The parent who understands this and therefore can handle his own impulse to react against it can teach the child something constructive not only about human relationships, but also about his attitudes toward God. All of this it seems to me is involved in our preaching about the cross which dramatizes the killing of the perfect God by the ugly man. If in their own actual experience children have had an experience of this kind of thing which they have been able to accept, later preaching about the cross can have an inner meaning for them. In the early family relationships we have the beginnings of the great spiritual struggles and aspirations of mankind. What the child gets out of these early experiences therefore is of basic importance in terms of his later capacity to comprehend these inwardly at an adult level.

Suppose we should ask the question how the doctrine of atonement could be taught to a three year old child. The question is of course, nonsense, but the fact remains that the three year old is wrestling with problems that are basic to a possible later understanding of the doctrine of atonement. The child senses a separation between himself and his parents and undertakes in ways strikingly similar to those observed in the Old Testament to achieve "atonement" with the parent. He offers a gift, or he promises to be "good" from now on, or he punishes himself or he "takes it out" on little brother or sister (the scapegoat method). None of these ways has real power of atonement. Only when the parent (human or divine) goes to the child in love and restores him to relationship does salvation from alienation take place. This is what the theologian means when he says that man cannot save himself, only God can save. Experiences in relationship of this kind contribute to the child's later understanding of and capacity to accept God's atonement.

We see today only the dim beginnings of the subject which we are discussing. Much more work and research needs to be done on it, but it is my strong conviction that this is an important field for the church to examine.

The JOURNAL *of* PASTORAL CARE

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EDITORIALS

Constructive Negotiations

The exchange of ideas between the Institute of Pastoral Care and the Council for Clinical Training has resulted in some definite accomplishments. First, there has been the adoption of four common goals for clinical training. These are:

1. To enable the student to gain an understanding of people, their deeper motivations and difficulties, their emotional and spiritual strengths and weaknesses.
2. To help the student develop effective pastoral methods for ministering to people, recognizing his unique resources, responsibilities, and limitations — as a clergyman.
3. To help the student learn how to work co-operatively with representatives of other professions and to utilize community resources toward achieving more effective living.
4. To encourage a desire for further understanding, particularly such as may be obtained through appropriate research.

There has also been established a Joint Committee on Clinical Pastoral Training which has already assumed some important assignments. The first of these is the possible merger of the *Journal of Clinical Pastoral Work* and the *Journal of Pastoral Care*. A joint editorial board has been appointed and instructed to prepare specific recommendations. A second project is a conference with seminary authorities as to the relationship of clinical training to theological education. This will constitute a continuation of the discussions first launched at Pittsburg in 1945.

Clinical pastoral training has now passed the quarter century mark, and these constructive steps constitute an appropriate demonstration of its maturity.

New Associate Director

The administrative staff of the Institute of Pastoral Care has been strengthened by the election of the Rev. Robert Leslie, Protestant Chaplain at the Boston State and Boston Psychopathic Hospitals and Clinical Associate at Boston University School of Theology. As a pastor Chaplain Leslie has had both parish and military experience, and in recent years he has been doing special work in group therapy. He received his doctorate from Boston University in 1948.

Our Contributors

Dr. Erich Lindemann ("Emotional Maturity") is Professor of Psychiatry in the Department of Social Relations at Harvard and also on the staff of the Massachusetts General Hospital . . . Ina May Greer, co-author with Dr. Lindemann, is a research associate in psychiatry and a course associate in the clinical pastoral training program at the above hospital. The Rev. Otis R. Rice ("Christianity and Psychotherapy") is Religious Director of St. Luke's Hospital, New York, and an instructor in pastoral theology at the General Theological Seminary. The Rev. Herman L. Barberry (". . . A Church Clinic") is Associate Minister at Marble Collegiate Church, New York, and his co-author, Clifton E. Kew is a clinical psychologist. The Rev. James H. Burns ("A Chaplaincy Program . . .") is an Instructor at Boston University School of Theology, Associate Director of the Institute of Pastoral Care, and an Associate Editor of this *Journal.* Dr. Allen S. Johnson ("The Physician-Patient Relationship.") is Visiting Physician at the Springfield Hospital, Springfield, Massachusetts. Mr. Robert H. Challinor ("A Student Evaluation . . .") is a candidate for the Episcopal ministry, studying at the Church Divinity School of the Pacific, Berkeley, California. Dr. Milton I. Levine ("Pediatrics and the Church") is Assistant Professor of Pediatrics at the Cornell University-New York Hospital Medical Center. The Rev. Reuel L. Howe, co-participant in the above symposium, is Professor of Pastoral Theology at the Virginia Theological Seminary.

ABSTRACTS

The Place of Grief Work in Mental Health: William Fred Rogers; Boston University, 1948.

The central problem of this study arose from the fact that some psychiatrists in studying certain psychosomatic diseases discovered that unresolved grief seemed to be a major etiological factor. Upon further study they discovered that grief is a traumatic experience of much more consequence than generally had been supposed by either laymen or professionals who deal with bereaved persons. It is the purpose of this study, (1) to discover the psychological needs of bereaved persons and (2) to discover what resources religion has for meeting these needs.

The thesis of this study is that clergymen have a key relationship to many bereaved persons, and, if properly trained, are in a position to help them do the necessary grief work. However, clergymen, as a whole, are unaware of the psychological needs which the bereaved have, and are inadequately prepared for their task. This study seeks to bring together psychological understanding of the needs of the bereaved and the resources of religion which the clergyman has at his disposal.

The literature in this field is limited as grief has not been studied extensively. Psychiatrists have had some experience in dealing with distorted grief reactions due to unresolved grief, but little has been done with immediate uncomplicated grief until recently. Religious literature is mainly theological in its approach, and serves psychological needs without any apparent awareness as to what the needs are or how they are being met.

The study begins with a survey of historical religious practices pertaining to burial and grief reactions. The theories back of many of these practices would be questioned by the scientifically trained, but the practices themselves served practical psychological purposes. A questionnaire study made by Rollin J. Fairbanks, director of the Institute of Pastoral Care, shows that many modern clergymen have an inadequate conception of the grief work which needs to be done immediately. Orthodox Judaism achieves much good psychological work in its customs and rituals, as do some Protestants in their modern use of the wake.

The second phase of the study is an examination of pertinent psychological literature. Studies in melancholia, depression, and psychosomatic diseases helped to delineate the field. They showed some of the results of unresolved grief and marks of distinction between acute grief and these other maladies. Lindemann's studies in bereavement clarified the picture in uncomplicated grief, showed the usual reactions to it, and indicated therapeutic measures which were effective in rehabilitating the bereaved. Fuller development of the picture is obtained by personal interviews with three psychiatrists and a pastoral psychologist.

Material obtained from psychological sources consists of three investigations: (1) The first is the psychodynamics of grief. This is an analysis of grief to show what it is. (2) The next phase is an examination of the ways in which the bereaved react to grief. (3) The final factor is a discussion of the psychological needs which bereaved persons have. This prepared the way for consideration of appropriate therapeutic measures.

A more detailed analysis of the above classifications gives a fuller story. In the psychodynamics of grief the following factors are found: (1) A broken interpersonal relationship is the basic factor, and the one from which the others derive. This is most clearly seen in death, but is also present in many other separation situations. (2) The presence of a static image of the deceased is present in uncomplicated grief. If it is suppressed the result is delayed and probably distorted grief reaction. (3) Another factor to be considered in grief is that it is an emotion. There is a distressing disturbance which is painful to the bereaved. The strength of the emotion is determined by the meaning which the deceased had for the bereaved. (4) Ambivalent feelings are also present in most bereavements. In some instances either the negative or positive feelings may be minor, but often both are strong enough to cause complications. Interpersonal relations even with a parent or spouse contain elements of both love and hate. When bereavement releases the love in grief it is apt, also, to release the antagonism which is present but may have been suppressed. (5) Guilt feelings are usually

present as part of the psychodynamics of grief. They may be very intense even though there is no foundation in fact for them. There may have been actual failures or abuse of the deceased, but the guilt feelings may be out of all proportion to the actuality. Another source of guilt feelings may arise out of hostile feelings which during the life of the deceased have been completely suppressed, but now have been released into consciousness, and of which the bereaved is thoroughly ashamed.

Analysis of the reactions to grief shows that the first and most obvious one is a (1) certain somatic syndrome. This includes difficulties in breathing and a feeling that all is not right with the digestive tract. There is a feeling of exhaustion, and a subjective distress described as a mental pain or tension. (2) A second factor discovered in the reaction to grief is an increased activity. Restlessness, continued movement and a rapidity of movement are noticeable. (3) While there is the increase in activity, however, there is also a loss of behavior patterns. The ability to initiate behavior may be lost. Even the ability to find meaning in daily routine is undermined. (4) There are individual differences in reaction to grief. The meaning which the deceased had for the bereaved is a very vital factor in determining the intensity of the reaction. Also important are the number of other contacts which the bereaved has, and the vitality of the former interpersonal reactions between the deceased and the bereaved. (6) Morbid grief reactions may take various forms. (i) There is first a delay of reaction and then (ii) one of various kinds of distorted reactions.

Needs of the bereaved include the following: (1) There is strong need for support from others. This may be taken care of informally by the interest and sympathy of friends or it may require the professional care of a counselor. (2) The bereaved needs to accept the pain of bereavement. To avoid delayed and distorted reactions it is essential that grief work be done immediately after loss. (4) Similarly there is need for the verbalization of feelings of hostility and guilt and (5) for the catharsis of the fear of insanity. An emotion needs to be released, and the best form of release is verbal expression. (6) Emancipation from the deceased is a universal need of the bereaved. While the need for (7) security and (8) satisfaction gives rise to the need for (9) the formulation of new relationships. More basic needs are for (10) unity of experience, for (11) purpose in life, and for (12) permanence in the structure of life. Underlying other needs is (13) the need to be treated as a person.

Religion has certain resources for meeting the needs of the bereaved. Belief in God and its corollaries give the individual feelings of security and value, while the practices of the church allow for confession and resolution of emotional tensions at a time when the need is greatest. The fellowship of the church allows for the formation of additional interpersonal relationships.

The fact that these resources are available holds the implication for the minister that he know both the needs of the bereaved and the resources of religion, and that he be instrumental in bringing the two together.

General conclusions reached in this study are: (1) Grief is a strong emotion arising from broken interpersonal relationships which comes with varying degrees of intensity to all people. (2) Attempts to deal with grief in the past have been partially successful in establishing emotional health, but there have been many failures resulting in distorted reactions. Religious attempts at comfort and its emphasis on immortality often have been premature. (3) The minister who knows the psychological needs of the bereaved has resources in his religion which enable him to be of assistance in helping the bereaved to do grief work and to attain emotional health.

Group Therapy as a Method for Church Works: Robert Campbell Leslie; Boston University, 1948.

The Christian Church has always been interested in therapy but it has shown little real understanding of the great therapeutic possibilities that lie in its group activities. It is the purpose of this dissertation to help the church to understand better how its groups can be used to accomplish significant therapy. By applying to church work the principles and methods found effective in group psychotherapy this dissertation helps to make available to the church some of the significant insights discovered in medical research in group treatment. The emphasis is not on the creation of new church groups designed especially for therapy but is, instead, on the more effective use of existing groups.

The dynamics of group therapy are first set forth in chapter two in terms of their structure and function. Chapter three surveys groups activity in the Christian Church showing how some of the dynamics of group therapy have been empoyed consciously or unconsciously throughout the history of the church. Chapters four and five trace the emergence of the principles of therapy in specific group experimentation in medical and psychiatric clinics and give illustrations of contemporary practice. Chapter six presents a detailed study of the Classes in Applied Psychology at the Boston Dipensary as a typical instance of effective therapy and describe a statistical study which supports the claims of the class. Chapter seven describes the program of group activity in a typical church and points out how the church can benefit from the application of insights gained from group therapy.

The dynamic principles of therapy in groups of all types are fundamentally the same. Classified in terms of their structure or the patterns of relationship they are: (1) interstimulation, which is the intensification of the central emotion; (2) interaction, which is the modification of behavior as a result of interpersonal activity; (3) transference, which is the warm relationship established between the group member and the leader and between the member and the group; and (4) identification, which is an association with other persons resulting in a reproduction of characteristics found in others or in the group. The dynamics classified in terms of their function or the results achieved are: (1) enlarged confidence, which members gain through association with a group; (2) socialization, which is activity stimulated on a social level; (3) re-education, which is accomplished more easily in the group situation; and (4) a laboratory in social living, which is found in the creation of a reality situation.

Many of these dynamic forces appear in group activity throughout the history of the Christian Church. Typical creative groups have been found in groups as the twelve disciples, the Apostolic Church, the Montanists, the Monastic Movement, the Waldenses, the Franciscans, the Friends of God, the Brethren of the Common Life, the German Pietists, the Anabaptists, the Society of Friends, the Methodists, the Evangelical Revivals, the Christian Communistic Communities of Amana and Oneida, the Iona Community, the Christian Scientists, the Emmanuel Movement, the Oxford Group Movement, and in the contemporary First Community Church in Columbus, Ohio. From a study of such groups it becomes apparent that creative, interacting groups have been at the core of the vitality of Christianity throughout the ages.

The most helpful scientific work in analyzing group therapeutic processes has come from medical circles. Dr. Joseph H. Pratt of Boston founded scientific group therapy when he began to experiment with class treatment of tuberculosis in 1905. In later years this work was carried over into the field of psychosomatic

medicine and eventually into the treatment of the psychoneuroses. Dr. Pratt's Thought Control Class, organized in 1930, was the first of several similar efforts at dealing with psychoneurotics in medical clinics. Another line of development centered in mental hospitals under the leadership of such therapists as Marsh, Lazell, Wender, Schilder, and others. A third line, begun by Dr. Jacob L. Moreno in Vienna in 1908, stressed more-than-verbal methods and developed into such work as psychodrama and play therapy.

Contemporary practices in group therapy which illustrate methods and principles of value for church work fall into two general classifications, methods of verbalization and more-than-verbal approaches. Verbal methods include such practices as the spiritual approach illustrated by Alcoholics Anonymous, the intellectual approach illustrated by Sherman's work with Navy men, and the analytic approach illustrated by Schilder. The more-than-verbal methods include such practices as the psychodrama of Moreno and the activity therapy of Slavson.

A detailed study of the Classes in Applied Psychology with which the writer is intimately connected indicates how a group can be used to further therapy and suggests methods that could be employed by the church. A study of results as reported by class members in a questionnaire indicates that at least 67 per cent of those attending five or more sessions have received benefit. This significant therapeutic result can be attributed largely to the group situation.

The need of the so called normal person for therapeutic group association is indicated by the prevalence of psychoneuroses in our society and is further substantiated by the studies conducted at the Peckham Pioneer Health Center in London. Through its group organizations the church can provide the satisfying, interpersonal relations so greatly needed in our day. A study of the rather typical organizational program of St. Mark's Methodist Church indicates the wide diversity of group activities that are available to meet the needs and interests of its members. Such existing groups, however, can serve a greater therapeutic purpose by utilizing insights gained from group therapy. The significance of interpersonal relations and the value of a laboratory-for-life approach need to be recognized. The leader needs to be trained in understanding group dynamics and in seeing his role clearly as a catalyst and an instigator of group interaction. A democratic atmosphere needs to be created in order that the group members may interact creatively. The group needs to be developed around common purposes and should be flexible enough for a continuous reorganization in terms of needs. The goal of religious group activity should be a creative fellowship in which the healing and development of the members in their adjustment to life is a primary consideration.

Several conclusions are drawn from this study of group therapy and its application to the church.

1. The church has a unique opportunity for aiding maladjusted persons through its group organization provided that the potentialities of group activity are recognized. No other institution is better prepared to provide such comprehensive coverage of all age and interest groups, and no other group organization is so committed to such altruistic purposes with such inclusive membership.

2. Because the church has given little attention to research in group processes, it is desirable that continuing study be made of the findings of group practice in other fields. Group processes are best understood through clinical observation of the functioning groups and such work has been carried on largely outside of the church.

3. Religious leaders need to be trained for their role in group activities since a major portion of the program of the church is carried on through groups. This training should include the acquiring of skill in using approved methods of sociometric research through clinical observation, recording, and study of interacting groups. With such trained leadership the church can make its own unique contribution to the better understanding of groups.

4. For effective group work the religious leader needs an understanding of dynamic, interpersonal psychology. Church groups do not accomplish their purpose until they become creative, interacting fellowships in which individual motivations are understood, personality mechanisms are accepted, and opportunities for modification of behavior are provided. Church groups need to meet the needs of people in terms of high purposes and constructive goals.

5. The church needs to develop a more functional approach in which the traditional atmosphere gives way to a democratic, voluntary atmosphere. Through its fellowship groups the church can become a laboratory for living in which individuals learn how to meet life through experimental efforts in a relatively controlled situation. Maturity in spiritual appreciation as well as in social adjustment is stimulated not through doctrine imposed from above but through personal experience in an actual social setting. The church has a real opportunity for meeting some of the urgent health needs of our society through its creative group activities.

Additional copies of these abstracts may be obtained on application to

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CORRESPONDENCE

To the Editors:

Your *Journal* is being circulated among the members of our Cooperation Committee of Physicians and Clergy and is highly appreciated. I enclose a new German journal on pastoral care called "The Way to Soul" (*Der Weg zur Seele*) in which is an article of mine. I regret I cannot translate it for you.

I was invited as lecturer to Austria last summer to give an address about "Psychotherapy and Views of Life" to psychiatrists, physicians, clergy, and social workers from Austria and Denmark. The conference was held by the Austrian government and the Danish Red Cross and twenty-five participated from each country and it was very interesting.

The cooperation in Austria too is going on. They have an Institute of Pastoral Medicine whose leader is a university tutor, Dr. A. Niedermeyer and his assistant, Dr. I. Caruso, of Vienna. It was very instructive to meet these two and other Austrian authorities. I learned a good deal about the cooperation in that part of Europe.

VILLY BAUNBAEK

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BOOK REVIEWS

The Mature Mind: Harry A. Overstreet; W. W. Norton, New York, 1949. 295 pp. $2.95.

A couple of decades ago Harry Overstreet's *About Ourselves* was deservedly the best popular book on psychology for everyday living. In *The Mature Mind* he proves again that a philosophical perspective and high skill in writing can tell things to the public that few professional psychologists are able to communicate. In one of many memorable phrases he writes, "Our culture goes on burying its psychological gold in the Fort Knoxes of specialized scholarship." Since "the characteristic knowledge of our century is psychological," this becomes serious. Getting the essence of psychological knowledge into the hearts and minds and actions of all thoughtful men then becomes the theme of his book.

The author does this through the leading concept of maturity, i.e., we need to become mature psychologically. If this central idea, and any or all of its tributaries, are subjected to close examination, serious faults can be found with them. Adults in difficulty are not merely hanging on to childhood patterns. And yet one must concede the virtue in a central concept like maturity for getting thought moving in new channels.

The book throughout oversimplifies the problem, as will be especially clear to readers of this journal in the chapter on religious maturity. Augustine was not quite so unpsychological as the author makes him, and Pelagius not quite so right. And yet even here we need to concede that the author does stimulate constructive thought.

SEWARD HILTNER

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Mental Hygiene: Herbert A. Carroll; Prentice-Hall, New York, 1947. 329 pp. $5.00

This is a text-book on mental hygiene written by the chairman of the department of psychology at the University of New Hampshire. As such it is another indication of the much-to-be-welcomed growth of interest in the dynamics of human behavior on the part of our academic psychologists.

The present text gives us an "overview" of the field of psychopathology and mental hygiene in simple and readable form. It is chiefly a compilation, culled from many authorities, with no attempt to offer any fresh or original contribution.

In the field of religion, where new insights from the standpoint of mental hygiene are so much needed, this book is particularly disappointing. Religion is given less than a page of space and the church is dismissed somewhat patronizingly as one of a community's many agencies, such as the Boy Scouts, the Campfire Girls, the service clubs, women's clubs and moving picture theatres, which exercise considerable influence upon the emotional stability of its members. He opines that mental hygienists, far from being opposed to religion, welcome the contribution it can make. Human beings need religion, but it must be a religion that fulfils their desires (!!) if they are to grow in emotional strength.

Professor Carroll's treatment of psychopathology undoubtedly reflects the prevailing views. This reviewer is nonetheless disappointed to find no recognition on his part that anxiety states and the acute psychoses may be manifestations of nature's power to heal and as such analogous to fever or inflammation in the body. All schizophrenic psychoses he lumps together indiscriminately as having a bad prognosis.

ANTON T. BOISEN

•

Emotional Security: Sapirstein, M. R.; Crown Press, New York, 1949. 291 pp. $3.50.

Dr. Sapirstein states his aim as that of giving as complete a picture of psychoanalysis as is possible within the confines of one volume, with special emphasis on the contributions the discipline has to make toward effective daily living and to those who are seeking to achieve emotional security. He has four things to offer the clergyman: (1) a very readable account of the conflicting — and complementary — psychoanalytic schools and theories, and a suggestive explanation for the vexing problem of why certain people develop a specific psychosomatic illness and not another; (2) a very interesting discussion of anxiety as a disturbance of the equilibrium between the individual and his environment, the causes of this rupture of adaptation, the catastrophic effect of failure to make proper contact with other human beings (isolation), and the characteristic defenses against the pain of too great anxiety; (3) a study of hostility as a specific breakdown in adaptation in response to frustrated dependency and thwarted expectations; and (4) a detailed analysis of romantic versus mature love, the patriarchal family of the nineteenth century and the losses and gains to both men and women which have come with the cultural changes of recent decades, and the new problems and dissatisfactions which ensue when liberated sexuality is divorced from personal responsibility and healthy dependency. Dr. Sapirstein belongs to the growing group of psychiatrists who are alert to the dangers of a spurious or unbridled self-sufficiency, aware that man is a social animal whose spiritual, mental, and emotional health is intimately linked to his relations with his fellow-man and his culture, and believe that a properly timed and directed, alternating and reciprocal dependency is not necessarily evil.

INA MAY GREER

•

A Study of Interpersonal Relations: edited by Patrick Mullahay; Hermitage Press, New York, 1949. 560 pp. $6.50.

Much of this collection of essays written by specialists for specialists in the treatment of mental illness lies outside the daily activities of the average clergyman. Among those sections of potential interest and value to him are Patrick Mullahay's preface and introduction, Clara Thompson's two papers on the psychology of women in our culture, Hilda Bruch's notes on the psychological aspects of obesity, and Kingsley Davis' stimulating study of the mental hygiene movement and the class structure. Dr. Mullahay points out that our concept of ourselves is shaped by the appraisals impressed on us by others and that while fixed biological needs and drives and their frustration play an important role in mental illness the ultimate matrix is the social context.

Dr. Thompson shows that Freud's hypotheses concerning women were based on traits determined by the culture, which granted her underprivilege, restriction of development, insincerity in regard to her sexual life, social and economic insecurity; and underlines the transition going on in the cultural pattern, which has resulted for women in emotional insecurity, dissatisfaction, inner conflict, the absence of satisfactory guides for the new pattern, and the necessity of working out her own solutions.

The esthetic handicap of overweight is perhaps better known to the clergyman than its medical and psychological import. Dr. Bruch discusses the difficulty the obese person has in making independent decisions, the feeling of security given by bulk, the typical family pattern of such patients with its small size, frustrated, dominant mother, and relatively futile father, and the need of the obese individual for emotional support as he seeks to diet. Dr. Davis' analysis of the relationship between the Protestant ethic and the mental hygiene movement should prove of especial interest to the theologican and may illumine for him some of the psychiatric concepts and goals which have seemed to him unnecessarily mechanistic and mundane.

INA MAY GREER

•

Character-Analysis: Wilhelm Reich; Orgone Institute Press, New York, 1949. 516 pp. $6.00.

Much of the earlier part of *Character-Analysis* is given over to a careful and detailed study of specific problems in therapeutic technique, particularly those centering around the handling of the negative transference and the analysis and resolution of the characteristic defenses of the patient, with special emphasis placed upon the need to understand and evaluate non-verbal activity. Case illustrations are presented in some detail with generous and illuminating excerpts from the patients' written and oral communications. The sections on inner loneliness and loss of effective contact with the outer world underline again the deadening effect of repression and the blocking of all emotional response which comes with the rigid inhibition of one.

As the book progresses, the historical development of Dr. Reich's thesis becomes clear and one can see why he has come into conflict with the International Psychoanalytic Institute, with various governmental agencies on both sides of the Atlantic, and with many of his fellow physicians. The minister may be disturbed, as are many scientists, by the tremendous weight which is placed on the role of genital activity in determining health and disease and by some of the details of treatment according to the principles of orgone therapy.

INA MAY GREER

•

Psychology for Ministers and Social Workers: H. Guntrip; Independent Press, London, 1949. 298 pp. 8/6 net.

One of the significant trends in theological education in American today is the increased interest in pastoral psychology. As this book indicates, there is a parallel interest in England.

While the theological colleges may be cautious in introducing new subjects, the English parish ministers are aware of the need for a more scientific approach

to personal problems in pastoral work. They are forming associations for spiritual healing and are learning to cooperate with psychiatrists and social workers. In fact, pastoral care in England is related more to social work than in America, and incorporates sociological as well as psychological principles. This relationship is illustrated in the title of Guntrip's book, which is addressed to both ministers and social workers.

As a minister who lectures in pastoral psychology at Yorkshire United Independent College, and as a psychotherapist in Leeds University Department of Psychiatry, the author is well qualified to speak on these subjects. The first half of the book deals with practical questions as to the application of psychology to counseling individuals, especially those burdened with anxiety. The second half of the book is a vigorous treatment of theoretical questions as to the nature and function of personality, integration and moral education, conscience and authority, the relationship of ethics to psychology. The author recognizes clearly the dynamics of personal relationships in a way that is equivalent to our recent perspectives of interpersonal psychology. The entire book deserves the careful reading of ministers and teachers of religion.

PAUL E. JOHNSON

●

From Failure to Fulfillment: John Martin; Macmillan, New York, 1948. 164 pp. $2.00.

The author attempts to show how the minister can use the insights of psychology in helping to solve individual problems of the parishioner. His aim is to begin with "normal psychological facts and conceptions" rather than with abnormal.

The minister will find in this book many illustrations which may be helpful in understanding problems he will meet in the parish. The closing chapters offer a fuller appreciation of the healing role of the Church through its spiritual ministry.

It is regrettable that the bibliography does not contain publication dates. Further, most of the references are to British authors with whom many American readers will be unfamiliar. The book is rather spotty. Readers interested in this field will find the material more adequately covered elsewhere.

HERMAN EICHORN

●

Handbook of Industrial Psychology: May Smith; The Philosophical Library, New York, 1944. 304 pp. $5.00.

Dr. May Smith has been for many years one of the foremost British experts in the field of industrial psychology. In this handbook she offers a summary of the field as she sees it, dealing with many of the standard topics such as the physical environment of industry, vocational selection, time and motion study, accidents, and absenteeism. She also has an interesting chapter on the problems encountered in industry by persons of the "nervous temperament." In her discussion, she never makes a parade of technical knowledge but always succeeds in stating the chief findings in each subject. She writes with ease and clarity, throwing in for good measure many shrewd comments from her fund of practical wisdom.

A beginner in the field of industrial psychology could not do better than read this book, provided he was also ready to read some others. Like many English scholars, May Smith tends to be satisfied with English work. One would never learn from her that Americans have been active in her field in recent years. For example, there is no evidence that May Smith has ever read *Management and the Worker* (1939), the classic by F. J. Roethlisberger and W. J. Dickson. Yet this book broke ground on important subjects, such as interviewing and the social organization of workers, that May Smith hardly touches. Her book remains only an introduction to the field. It is in no sense a complete survey.

GEORGE C. HOMANS

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Personality Projection in the Drawing of the Human Figure: Karen Machover; Chas. C. Thomas, Springfield, Ill., 1948. 181 pp. $3.50.

It will be of considerable surprise to many people to know that their drawings of the human figure reveal an amazing amount of information about their own personalities. This book is an outline of a method for interpreting such drawings. It is not intended for general reading; in fact it presupposes basic familiarity with dynamic psychology and psychoanalytical concepts. Dr. Machover, however, has avoided the monotony and boredom so often characteristic of scientific monographs.

Like other projective instruments this method apparently relies largely on data secured from testing "sick" personalities. Its present value is that it provides another useful tool for detecting evidence of pathology. Further clinical experimentation is needed to demonstrate the true scope of an admittedly fascinating diagnostic instrument. While the author recognizes the influence of cultural factors, it would seem to this reviewer that greater acknowledgment may be in order. The book has an excellent index and is attractively printed.

ROLLIN J. FAIRBANKS

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When the Doctor Says It's Nerves: Henry Jerome Simpson: Morehouse-Gorham, New York, 1949. 89 pp. $1.25.

This little book, planned for use by people suffering from psychoneuroses, "aims to give a simple, brief but factual account of how they happened to be nervous, what it means and does not mean, and what they must do to rid themselves of this particular form of torture." More than forty years of reading in this field and personal study and work with something over two hundred cases forms the background for the author's premises, according to the preface. Unfortunately, the book presents a rather naive explanation of neuroses on a superficial level. To the reviewer, it seems that this explanation is contrary to that generally given by modern psychiatry. It often confuses symptoms with causes. Methods suggested for treatment are strongly similar to Couéism and would seem to the reviewer to lead to repression and deeper psychoneuroses if given to any but the most superficial or mild cases. The book is full of oversimplifications. It is not recommended for either the pastor or the patient.

MALCOLM B. BALLINGER

Nervous Disorders and Character: John G. McKenzie; Harper, New York, 1946. 126 pp. $1.50.

This book contains four lectures delivered at Manchester College, Oxford, by John G. McKenzie, M.A., D.D. (Aberdeen), Professor in Social Science and Psychology, Paton College, Nottingham. The first lecture deals with the structure of character and personality disorders. "The psychoneuroses are the outcome of character disturbance." The roots of maladjustment are to be found in a defective character structure, Dr. McKenzie contends. If these maladjustments or disturbances are to be prevented or cured, a religious character must be developed. Character disturbances due to organic or constitutional causes are not included in the first lecture. Religious beliefs and attitudes are shown to be of central importance in determining the structure of character. A changed attitude toward religion and life can effect changes in the character structure. Many examples of such changes are given from the fields of psychology, psychotherapy, and pastoral counseling.

In the second lecture, ways of using psychology and psychotherapy in pastoral counseling are made clear by showing how the informed pastor may better understand the relation of a religious philosophy of life to mental health. A pastor with a well-informed spiritual technique can minister to the parishioner's basic needs for a unification of personality, for security, and for a sense of belonging. "The enjoyment of God should be the supreme end of spiritual technique. In that enjoyment we feel not only saved in the Evangelical sense, but safe." When one is conscious of belonging to God, hostile feelings disappear and anxiety is dispelled.

Mental mechanisms are described in the third lecture according to modern theories of psychology. Rationalization, projection, and displacement as mental processes operate in the spiritual areas of life. "Through a knowledge of these mechanisms" the pastor is able "to help people perceive what is active in their minds, and to act according to the reality of the situation."

In the final lecture, Dr. McKenzie gives five simple rules of mental hygiene which are worth the price of the book. Space and intrigue prevent the reviewer from quoting these excellent rules to be found on page 113.

Among other books by the author, *Psychology, Psychotherapy, and Evangelicalism* follows most nearly the thesis of his lectures in *Nervous Disorders and Character.*

THOMAS A. BRIDGES

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The Psychological Origin and Treatment of Enuresis: Stevenson Smith; University of Washington Press, Seattle, 1948. 68 pp. $1.75.

Bed-wetting, commonly regarded by many parents as the child's problem, is presented in this book as a problem that really has its origin often in the attitude of the parent toward the child. Back of bed-wetting, very commonly, lie conditions of insecurity and anxiety in the child. The relationship offered by the parent to the child does not contribute to feelings of security and confidence. "Until a child feels inner security he is hard to cure and is always ready to relapse." Again, "It is the spirit that exists in the house-hold that has most to do with producing wet or dry beds." Pages 23–36 present an excellent discussion of how

parents should change themselves and their attitudes toward their children. This section will help the parish minister in understandings that will enable him to counsel young parents more effectively.

REUEL L. HOWE

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Modern American Society: Kingsley Davis, Harry C. Bredmeier, Marion J. Levy, Jr.: Rinehart, New York, 1949. 734 pp. $4.50.

One of the persistent problems of the social scientist has been the analysis and definition of value. It is well to state, as the authors of this volume do, that values may be subjected to scientific study but that they cannot be *derived* from such a study. It is quite another thing, however, to remove all subjectivism from the scientist and to substitute the capacity to make non-evaluational choices and distinctions.

The authors have in a way sought to accomplish just this by selecting readings and essays which deal with American society in many of its ramifications. It is obviously meant to be a source book for a college course in anthropology, social psychology, or sociology. Ministers interested in securing an up-to-date reference on social readings which tend toward the practical rather than the theoretical issues will find it stimulating. When, however, they turn from such varied subjects as "The American Caste System," "Race Versus Democracy," "The Urban Way of Life," "Adolescence and Parent-child Relations," to "The Separation of Church and Society," they may be disappointed. This reviewer is deeply appreciative of the contributions which the social sciences have made to a deeper understanding of people, but he cannot help but feel that the selection of readings — particularly Chapter XVI, "Varieties of Religion" — signally indicate the limitations of the non-evaluational approach.

JOHN ARTHUR SAMUELSON

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The Sociology of The Family: M. C. Elmer; Ginn, New York, 1945. 519 pp $4.00.

While this book is written primarily for the sociologist and students of the family, it is the kind of text which will benefit all who work with people and try to guide them into purposeful living. Professor Elmer's volume is in no sense a handbook for marriage, nor a guidebook for parents in solving family problems, yet it offers many practical suggestions for helping the family and its members to make their adjustment to society.

If a clergyman feels that he is not well qualified by training and experience to counsel in family matters, and wants an all-purpose book dealing with the family as a going concern of society, both controlling and being controlled, he will find this a most valuable study. An extended bibliography at the close of each chapter will give additional reading. The author's suggestions for further study will help those who use the text as a reference in a course on Christian marriage, home-making, or living together in the family. Since it is the home, the school and the church which have such a lasting contribution in molding the lives of our children, the latter will need to give more concern as to how best modern research can be employed to assist the ecclesiastical bodies in their

efforts to strengthen family life, and enable the individual to make his best contribution to society. Such a book as Professor Elmer has written should help Christian leaders in doing this.

GILBERT APPELHOF, JR.

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The Marriage Handbook: Judson T. Landis and Mary G. Landis; Prentice-Hall, New York, 1948. 513 pp. $3.50.

Although calling itself a handbook this is actually the same volume as the authors' textbook, *Building a Successful Marriage* minus the latter's chapter-end discussion questions. The book is profusely illustrated with charts, graphs, cartoons, and half-tones. The treatment of the usual topics found in such a book is sound although some of the discussions are a little brief. Dr. Landis supervises the teaching of marriage to hundreds of freshmen at Michigan State College. The book grows out of his teaching experience and research. The ethical positions taken are conservative. There is a chapter on religious attitudes and family life and one on mixed marriages. At the end there is a nationwide list of marriage counseling agencies and a bibliography annotated and arranged for various age and interest groups. For the pastor who wishes briefly to orient himself in this field, or who wishes to conduct classes for engaged or recently married persons, this is a useful book.

HERBERT D. LAMSON

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Marriage Counselling: David R. Mace; J. A. Churchill, London, 1948. 164 pp. 8 s. Net.

Described as "the first full account of the remedial work of the Marriage Guidance Councils" in England, this little book provides a comprehensive and enthusiastic account of a constructive program aimed at strengthening and salvaging marriages.

Although the author scrupulously refrains from citing any specifically clinical (i.e., case) material, nevertheless he presents a clear, detailed account of the whole therapeutic procedure. Beginning with the initial interview and carrying through diagnosis, the keeping of records, possible referrals, and specific treatment. This is supplemented by a break-down of the areas of marital conflict and a thorough discussion of the selection and training of "marriage counsellors" (English spelling). There are also four brief appendices containing information as to principles and policies, descriptive literature, a medical concordat, and tentative conclusions based upon an early study of the first thousand marriages accepted for treatment.

It would appear, for instance, that elderly bachelors marrying late had the greatest difficulty adjusting to marriage, while spinsters "were average in this respect. . . . Widows and widowers appear to be very good marriage prospects. Divorced women achieve average happiness in second marriages, but the record of divorced men is apparently very poor indeed."

The incidence of sexual maladjustment was "very high" — viz., 50 per cent. One quarter of the couples studied showed gross ignorance in this field. Nearly 30 per cent of the wives "were sexually unsatisfied." It was also noted that pre-marital sex relations showed a definite correlation with later marital trouble.

More than half of the group studied "professed a religion" while 37.6 per cent showed lack of "any adequate philosophy of life." As to therapeutic results it was estimated that 275 marriages were "almost certain to improve" and 423 "might improve." It was felt that the future could not be predicted for the remainder.

It would appear that the approach to marriage guidance advocated by Dr. Mace is more problem-centered than client-centered. This does not mean, however, that he is unaware of the individuals. The primary emphasis seems to be on behavior rather than attitudes, and there is too little awareness of the *dynamics* of interpersonal relations.

Although pre-marital counseling is discussed in only one, brief chapter, some excellent observations are made. The author points out the futility of considerable pre-marital instruction and wisely stresses the opportunity and preventive value of early *post*-marital counseling.

Throughout the book one gathers the impression that the clergy are viewed primarily as *specialists* (not unlike the physician, psychologist, and the social worker) and not as marriage counselors. In fact any professional person is by reason of his special training apparently disqualified. This point is admittedly over-stated but it perhaps conveys an impression which is difficult to understand here in America. There would appear to be considerable discrepancy between English and American training of clergy in the pastoral field.

Dr. Mace and his colleagues are to be congratulated upon their program for strengthening marriages in England. We eagerly await further reports.

ROLLIN J. FAIRBANKS

•

Family Counseling: Practice and Teaching: Jewish Family Service, New York, 1949. 48 pp. $1.00.

This booklet is the hard-won product of seventy-five years of growing service offered by the Jewish Family Service of New York City. It contains three papers given at a professional meeting commemorating these seventy-five years; simultaneously, it is a tribute to Miss Frances Taussig, for thirty years Executive Director of this outstanding organization.

The first paper is Miss Taussig's address: a review of trends and growth. It has much to offer clergy in executive positions, or board members in Church-related or community-sponsored organizations. Dr. M. Robert Gomberg's paper, "Principles and Practices in Counseling," utilizes his experience as an effective family counselor and his rare ability to put on paper with a minimum of "loss" the content and essentially dynamic process of the counseling relation-begin ship.

"Principles and Practices in Supervision" is offered by Frances T. Levinson. It will interest only those who supervise others actively engaged in helping families in trouble. This paper is one of the few published on this involved and important subject. One appreciates her stressing equally the needs of the supervisor with those of the counselor.

HENRY H. WIESBAUER

The Problem Family: A. S. Neill; Hermitage Press, New York, 1949. 224 pp. $2.75.

Mr. Neill writes, not as a social scientist, but as an educator, who for twenty-seven years has run a co-educational boarding school for about seventy children in England. One can infer from his book that he has a talent for creating free, happy relationships in his school, contrasting strongly with the repressions and evasions which he believes are characteristic of English middle-class family life. Mr. Neill's enthusiasm for his boys and girls is contagious; but his tendency to rant soon alienates the sympathy of the reader. His hostility to organized religion is a corollary of his back-to-nature philosophy; he regards sexual freedom for children and adults as practically a guarantee of a good and happy human race. Mr. Neill's ideas on sex education have long been commonplace among the more sophisticated parents of our society; and while their application has probably improved family life, they cannot, alas, be said to have solved such basic problems of human nature as the child's desire for exclusive possession of the parent, jealousy among siblings, or the mother's struggle to reconcile the needs of her own personality with those of her family. The serious student of family problems will find this an unbalanced book, and the average parent will be repelled rather than helped by it.

ELIZABETH B. LINDEMANN

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The Secret of a Happy Marriage: Roy A. Burkhart; Harper, 1949. 75 pp. $1.00.

This little volume of only 75 pages, written by Dr. Roy Burkhart on the 30th anniversary of his marriage, on the basis of his own experience, as well as that of his long experience as a marriage counselor, contains sage advice for any couple contemplating matrimony, expressed with commendable beauty, simplicity, and brevity. This would be a helpful gift to an engaged couple or to a couple at the time of their marriage, and is accordingly appropriately bound in white.

GARDINER M. DAY

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Men and Women: Gilbert Russell; Student Christian Movement Press, London, 1948. 125 pp. 6s.

This book deserves to be widely read. It is not a book about sex, though that aspect naturally enough is touched upon. It is about men and women in their relationship to one another. On the background of the three-fold purpose of marriage given in the Prayer Book Service of the Solemnization of Matrimony, Dr. Russell deals with the deep issues that face men and women today. He avoids none of the problems that adhere to the intimate relationships of men and women, and he brings to bear upon them, discernment that is both lucid and Christian.

The chapter entitled "Marriage Law" will be especially helpful to parish clergy in their consideration of the problems of divorce: the whole book will be a useful guide to them in their marriage counselling.

RUSSEL F. BROWN

Sex and Marriage: edited by Burdett Wylie, M.D.; The World Publishing Company, Cleveland, Ohio, 1949. 348 pp. $3.00.

In his introduction to this volume Dr. Wylie says: "The difference between adjustment and maladjustment in marriage is frequently a matter of common sense plus an understanding of the elementary principles of psychology and physiology." He then proceeds to present fifteen essays by at least as many authorities, which discuss various aspects of sex as related to marriage. All of the articles have previously appeared elsewhere, some as early as 1922! In most cases, however, the original date of publication in no way implies an antequated point of view. The one exception is chapter 9 ("Prenatal Care and Birth") which is so out of date that this reviewer wonders why it was chosen.

It is inevitable that in any symposium some variations in emphasis, if not actual contradictions, will arise. For instance, we find Dr. Thurman B. Rice writing somewhat scornfully of instruction regarding various positions for sexual intercourse while Dr. Eustace Chesser proceeds to provide just such information!

Chapter 3, "The Objects of Marriage" by Havelock Ellis, leaves much to be desired. While the criticism which he levels at the Church is thoroughly justified, the resultant *rationale* for marriage is an almost sentimental mixture of humanism and hedonism. This may have been acceptable in 1922 when it was first published, but today the Christian concept of marriage is preferred by more and more of our young people.

It is doubtful whether the chapters on "Venereal Diseases" (10) and "Abnormal Sexuality . . ." (15) add anything to this volume. There also appears a maximum emphasis upon physiology and only a minimal awareness of the dynamics of personality. Despite these criticisms, however, the book should prove a useful reference for those who can profit by a fuller knowledge of this important aspect of marriage.

ROLLIN J. FAIRBANKS

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Husband Security: Huldah Temple; the William-Frederick Press, New York, 1948. 85 pp. $2.00.

In *Husband Security* Huldah Temple proposes to do a little to counteract divorce. At her best she recommends various ways of expressing a continuing and intelligent love toward the erring partner. However, the reader has difficulty holding to this core of truth amidst the distraction of a pseudo-psychology, historical inaccuracy, an all too robust manner of speaking, a conviction of female superiority, and apparent lack of a sense of humor. Such deficiencies tend to render the book of limited value to the experienced reader — possibly harmful to the average.

JOHN S. KROMER

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Parent and Child: Catherine Mackenzie; William Sloane Associates, New York, 1949. 323 pp. $2.95.

The author gives us the latest findings in mental and physical hygiene, not limiting them to a narrow aspect, but showing wide concern for the welfare of children and young people in varied relationships — in fact, through all the stages of their upbringing. The style is popular, almost entertaining, and Miss

Mackenzie acts in the capacity of a reporter to keep us up to the minute on the advice being given by the wisest physicians, scientists, teachers, and research workers in the field. She touches on parent education, family living, the problems of different age levels and their manners and morals, the average child, and the exceptional child. We may not agree with every idea presented, but we shall not be bored. It should prove a useful book for the parish minister who wants a glimpse of the best modern thought in these areas, and it could be lent to many parents who would not take up a book divided into long, conventional chapters.

DORA P. CHAPLIN

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Junior Speaks Up: Irving S. Abrams, M.D.; Macmillan, New York, 1948. 164 pp. $2.50.

Dr. Abrams has resorted to a drama in order to present his ideas on the care and nurture of children, flavoring it with his own brand of humor. Junior — anybody's baby — is the hero, and others in the cast include Mom and Pop, the physician, nurses, neighbors, and "Shadow", the invisible confidante. The book will have little value for the pastor.

ROSEMARY CLARK

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Youth Asks About Religion: Jack Finegan; Haddam House, New York, 1949. 192 pp. $2.00.

The author, a minister of the Disciples of Christ and Professor of Old and New Testament Literature and Interpretation at the Pacific School of Religion, has assembled 100 of the innumerable questions which youth are asking about religion and its relationship to life. The answers (which are also provided) reflect what might be called progressive religious thinking. These concise and interesting responses are further strengthened by a good bibliography. Some readers may question the author's comment that the distinctive emphasis of the Episcopal Church is an aesthetic one. The book offers excellent material for discussion groups.

NORMAN SPICER

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The Rehabilitation of the Physically Handicapped: Henry H. Kessler, M.D.; Columbia University Press, New York, 1947. 274 pp. $3.50.

Dr. Kessler has given us a history of rehabilitation, "the infant tool of social medicine," as well as a report of methods he has developed through years of experience in the New Jersey Rehabilitation Center and during the war as director of rehabilitation, both overseas and at the Mare Island Naval Hospital, California. The book, however, fails to consider the emotional problems involved in adjusting to a handicap.

Although limited by title to the physically handicapped, the author includes a chapter regarding the rehabilitation of the mentally and emotionally disabled. The chapter serves as a reminder of the scant amount of attention rehabilitation of severe psychoneurotic and psychotic patients receives at this time. Dr. Kessler points out that rarely can we judge with any accuracy the disabling extent of a handicap due to the inability to measure the body's tendency to

compensate for loss, "the body's safety factor," as he terms it. His book becomes a plea for an enlightened approach to the problems of these individuals — an approach which takes into consideration the body's ability to compensate for handicap and which will encourage these individuals to fill a useful place in society. The Chaplain will find it helpful in his understanding of the disability that grips the patient as well as its implications for the whole man.

ROBERT M. TRENERY

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Take Up Thy Bed and Walk: David Hindshaw; H. P. Putnam's Sons, New York, 1948. 262 pp. $2.75.

This book traces the history of the treatment of disabled persons and urges greater efforts for better handling of the problem of rehabilitation. It advocates treatment of the *whole* patient by a staff of specialists representing medicine, physical therapy, occupational therapy, nursing, psychiatry, psychology, social work, vocational guidance, and education. It gives helpful, definite instructions for the establishment of local rehabilitation centers, pointing out the proper parts to be played by physical medicine, psychosocial adjustment, and vocational adjustment. It urges that more general information be given to the disabled themselves, and to doctors, social agencies, and employers on the desirability, possibilities, and facilities, for rehabilitation.

Although the book takes its title from Christ's exhortation to the palsied man, it virtually condemns Christianity for failing to live up to its Christian concepts. The author fails to give any place whatsoever to pastoral counseling as an aid in rehabilitation of the disabled.

MALCOLM B. BALLINGER

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Teach Us To Pray: Charles Francis Whiston; Pilgrim Press, Boston, 1949. 243 pp. $2.50.

Since the war a renewed concern about personal devotion has brought forth various significant volumes on prayer and inspired republication of many devotional classics — Fenelon, Scougal, a Kempis, Bunyan, et al. This book by a professor of Theology at the (Episcopal) Church Divinity School of the Pacific, recently a Massachusetts parish minister, is a notable addition to such helpful literature. As Nels F. S. Ferre says in his foreword, it comes evidently from a prayerful pastor's own life, in such a way as to enable others to discover abilities in prayer.

No startling new treatment of prayer is given, but rather a quiet exploration of the age-old proved "notes" of personal devotion. Expectancy born of Christian doctrines of God and Christ; adoration, self-giving, intercession, and thankfulness as elements of prayer (perhaps leaning backwards slightly to avoid emphasis on petition); practical methods for the retreat and school-of-prayer, with brief bibliography — these are all lifted up for a steady, persuasive view. Particularly strong is Dr. Whiston's insistence that laymen, and ministers too, do not pray effectively without training and specific guided experience in prayer. The book is an admirable tool for any pastor's use in claiming and relaying to others the power of personal devotional life.

JOHN OLIVER NELSON

A Catechism of Christian Doctrine: (Revised edition of the Baltimore Catechism) by the Confraternity of Christian Doctrine; St. Anthony Guild Press, Paterson, New Jersey, 1949. 426 pp. $1.00.

This is a Roman Catholic dogmatic text for secondary schools, covering the creeds, the commandments, the sacraments and prayer. It says essentially what Roman dogma always says, but is instructive for the Protestant pastor in showing what the Roman church conceives to be a proper popular interpretation of its doctrine.

The book has been examined from the point of view of Protestant pastoral care. Of course the chief difference is in the authority of the priest and church. There are, however, sidelights suggesting that doctrinal interpretation is not entirely oblivious of such things as democratic trends in the United States.

The Commandment to honor parents, we are told, "deals explicitly with the duties of children toward their parents," but also "implicitly with the obligation of parents toward their children." While not stressed, the implication that "Parents should make themselves worthy of the honor which this Commandment imposes" is significant. Evolution of man from the lower animals is held to be unproved, but not to threaten doctrine if it were.

Yet such small signs are few indeed. A venial sin becomes mortal when the sinner thinks it is, thus betraying the basically compulsive character of Roman Catholic thought. The psychology involved in handling "impurity" is also plainly compulsive. "We should form the habit of praying immediately when we are beset by impure thoughts, desires, or imaginations. It is well to know by heart many ejaculations addressed to Our Lord and His Blessed Mother which we should repeat in time of such temptations." This is faculty and suggestion psychology with a vengeance.

The Roman sin theory as shown here is to the Protestant as the partial trait theory is to characterology. In examining our sins before confession, for instance, we should do it "carefully and thoughtfully, and attempting to remember all our sins." If we go to confession and have no mortal sin to confess since the last visit, "we should confess our venial sins or some sin told in a previous confession, for which we are again sorry, in order that the priest may give us absolution". The last phrase gives the clue.

Celibacy, "embraced for the love of God, is higher than the married state." An anxiety or generalized fear of sex becomes quite clear through the book, e.g., the amount of space devoted to impurity as against mere mentions of pride and sloth. "Sins of impurity and immodesty are extremely dangerous because human nature is strongly inclined toward them. . . ." The term used for social contacts with the other sex, dangerous to do with non-Catholics, is "company-keeping." Masturbation receives no explicit mention under any name.

SEWARD HILTNER

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The Problem of Pain: C. S. Lewis; Macmillan, New York, 1948. 148 pp. $1.50.

The problem of pain revolves around the meaning of divine omnipotence and divine goodness. In dealing with these concepts, Mr. Lewis shows first that omnipotence means power to do that which is intrinsically possible, not to do the intrinsically impossible. Secondly, he shows that the problem of reconciling human suffering with the existence of a God who loves is only insoluble so long

as we attach a trivial meaning to the word "love." God's love for us gives us what we need, which is not necessarily what we think we want.

In the chapters on human wickedness and the fall of man, the author argues that the possibility of pain is inherent in the very existence of a world where free agents can meet. He then deals with six propositions which must be raised in dealing with the problem of pain, of which perhaps the last is the most intriguing. Mr. Lewis says that only pain, of all evils, is "sterilized" or "disinfected" evil — i.e., pain of its own has no tendency to proliferate. When it is over, it is done. Both sin and error not only require removal of causes but also an undoing or repentance; pain, however, needs no such undoing.

From the point of view of actual use at the bedside of a patient who asks, "Why did God do this to me?" the book is of little use. It does, however, present a theological background from which one must work if he is to deal with parishioners adequately on the pastoral level.

E. EAGER WOOD, JR.

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Parson's Sampler: James W. Kennedy; Pilgrim Press, Boston, 1948. 230 pp. $2.50.

Parson's Sampler is a collection of the various types of public utterances of a clergyman. It is an attempt to use creatively the written and spoken word. The style is informal and rather breezy. The author has an exceptional facility for coining catchy titles and phrases, and his premise seems to be that the value of public utterances is in their popular appeal. To achieve this, spiritual values are often subordinated. For these reasons the book has a limited usefulness.

WILLIAM C. MUNDS

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The Parson Takes A Wife: Maria Williams Sheerin; MacMillan, New York, 1949. 204 pp. $2.75.

This is a book parson's wives would *enjoy*, but it does not present a true picture of a clergy family. It is Mrs. Sheerin's sophisticated sense of humor that makes one wonder whether laymen might feel a distrust because she seems more amused than sensitive to incidents in the family life and parish.

Mrs. Sherin, however, had a real understanding of the race problem in Richmond, sincere love for the parish in Chattanooga and (though she did not point it up) contributed much to every parish they served. One wishes, however, that she had not given the impression that the life of a parson's wife is really a lark. It is good to enjoy the life, but it should be enjoyed as a participant even more than as an observer.

JEAN CROWLEY

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Nancy Clark, Social Worker: Cora Kasius; Dodd, Mead, New York, 1949. 246 pp. $2.50.

Cara Kasius has written for high school or college-age girls an interesting novel which explains simply but forcefully the philosophy of social casework and depicts its various phases. Since it looks like a "girls' book," many adults might be inclined not to read it, but actually, a minister, teacher, or vocational adviser

could not find a better treatment of this profession. The only weakness is its oversimplification of the process of self-analysis and self-evaluation, which is for many young people a very difficult part of the discipline of becoming a professional caseworker.

JULIA WHITESIDE WARE

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Birthdays Don't Count: New York State Joint Legislative Committee on the Problems of the Aging, 94 Broadway, Newburgh, N. Y. Legislative document (1948) no. 61. Free upon request.

The report of this Committee to the New York State Legislature consists mainly of papers presented at a public hearing by outstanding geriatricians and gerontologists, and includes a tremendous amount of significant information on one of the state's most pressing problems. The recommendations of the Committee, in the form of several suggested bills, appear in an appendix. This first-class document might well serve as a model for other legislative committees.

Most of the report is of general interest, although some of the material deals specifically with the problem as it exists in the state of New York. Every minister in New York should read it and digest its contents, and clergy elsewhere will find it a veritable mine of useful information.

PAUL B. MAVES

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Social Adjustment in Old Age: Otto Pollak and Glen Heathers; Social Science Research Council, New York, 1948. 199 pp. $1.75.

In the words of the author, "This bulletin was planned to stimulate further research on the age changes to which older individuals have to adjust, on means of adjustment which are or could be put at their disposal, on factors which are correlated with the degree of adjustment which they achieve, and on measures of that achievement. Particular attention has been paid to analyzing how the studies of aging conducted by members of different social science disciplines might be interrelated in terms of the concept of adjustment."

This volume will serve as a helpful reference for all those who are engaged in work with the aged or research into their problems. Cast in rather technical language and designed for a highly specialized purpose, it will be of interest only to that exceptional parish minister who is concerned to test and to improve his professional skill in ministering to older people through clinical research and analysis of his own practice. It contains a condensation of present sociological and psychological knowledge about older people and a comprehensive bibliography of 387 references to guide further study in this field.

PAUL B. MAVES

•

Outwitting Your Years: Clarence William Lieb; Prentice-Hall, New York, 1949. 278 pp. $2.75.

This is one of a host of inspiration-self-help books for older people now being published. Written by a physician who has had wide contacts and an distinguished clientele, it covers the field of geriatrics with chapters on "Sex After Sixty," "Why Retire?" "Everyone to His Hobby," "New Jobs for Old," "It's Fun to be Old," etc. Like many such books it is filled with the clichés of good

advice but adds nothing fundamentally new to our understanding of later maturity. Although the author is deeply religious, his chapter on the role of religion in old age happiness is less than satisfactory, although he does prescribe religion and he believes in a cooperative relationship between pastor and physician. It is interestingly written, and might prove useful in boosting the morale of older people.

PAUL B. MAVES

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The Tides of Dawn: E. Louise Mally; William Sloane Associates, New York, 1949. 370 pp. $3.50.

An interesting novel which deals with the revolt of the Netherlands in the sixteenth century against the tyranny of Spanish rule and the Church. The book has no significance for pastoral care.

ROLLIN J. FAIRBANKS

OUR REVIEWERS

Seward Hiltner is Executive Secretary of the Department of Pastoral Services of the Federal Council of Churches . . . *Anton T. Boisen* is Chaplain at the Elgin State Hospital . . . *Ina May Greer* is a research associate in psychiatry at the Massachusetts General Hospital . . . *Paul E. Johnson* is Professor of Psychology of Religion at Boston University School of Theology . . . *Herman Eichorn* is a Unitarian clergyman who is doing graduate clinical study under the Council for Clinical Training . . . *George C. Homans, Jr.*, is Associate Professor in the Department of Social Relations at Harvard . . . *Rollin J. Fairbanks* is Assistant Professor of Practical Theology at the Episcopal Theological School and Lecturer in Pastoral Care at Harvard . . . *Malcolm B. Ballinger* is Prostestant Chaplain at the University Hospital, Ann Arbor, Mich. . . . *Thomas A. Bridges* is Chaplain of St. Luke's Hospital, Kansas City, Mo. . . . *Reuel L. Howe* is Professor of Pastoral Theology at Virginia Theological Seminary . . . *John Arthur Samuelson* is pastor of the Federated Church at Norfolk, Mass., and Protestant Chaplain at the Norfolk State Prison . . . *Gilbert Appelhof, Jr.*, is rector of St. Thomas' Church, Berea, Ohio . . . *Herbert D. Lamson* is Professor of Sociology at Boston University . . . *Henry H. Wiesbauer* is now doing graduate work at the University of Chicago . . . *Elizabeth B. Lindemann* is a former social worker and the wife of a psychiatrist . . . *Gardiner M. Day* is rector of Christ Church, Cambridge, Mass., . . . *Russell F. Brown* is rector of St. Peter's Church, Sherbrooke, Que., . . . *John S. Kromer* is rector of St. Paul's Church, Gardner, Mass., . . . *Dora P. Chaplin* is an Associate Editor of Curriculum, Department of Christian Education of the Protestant Episcopal Church . . . *Rosemary Clark* is the wife of a Connecticut pastor . . . *Norman Spicer* is in charge of student work at the Cathedral of St. John the Divine, New York . . . *Robert Trenery* is Protestant Chaplain at St. Louis General Hospital, St. Louis, Mo. . . . *John Oliver Nelson* directs the Commission on the Ministry of the Federal Council of Churches . . . *E. Eager Wood* is rector of St. Luke's Church, Blackstone, Va., . . . *William C. Munds* is rector of Christ Church Christiana Hundred, Greenville, Dela., . . . *Jean Crowley* is wife of a Michigan pastor . . . *Julia Whiteside Ware* is a caseworker with the Family Society of Boston and casework consultant for the Massachusetts Council of Churches . . . *Paul B. Maves* is Assistant Professor of Christian Education at Drew Theological Seminary and co-author of *Older People and the Church.*

NOTES AND COMMENTS

An excellent Institute on Marriage and the Family is being sponsored by the Church of the Advent, Boston. Mimeographed copies of the seven addresses may be secured for $2.25 a set. The address is 135 Mt. Vernon St., Boston 8.

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The Rev. C. Charles Bachmann has been called as City Missionary of the United Lutheran Department of Institutional Ministry, in Chicago. He will be in charge of the chaplaincy program.

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Clinical training is now available at the V. A. Hospital at Topeka, Kan. The course is for three months. Only applicants with previous training in mental hospitals are eligible.

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Appointments are available for Course Assistants, Resource Associates, and Clinical Associates at training centers under the Institute of Pastoral Care. Inquiries are invited.

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Chaplain Malcolm B. Ballinger of the University Hospital, Ann Arbor, is co-author with Dr. Ronald H. Girdwood of an article, "The Factors that Commonly Worry the Patient in Hospital" which was published in the *Edinburgh Medical Journal*, Vol. LVI, P. 347, 1949.

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The Family Service Association (192 Lexington Ave., New York 16) offers a helpful vocational pamphlet entitled *Find Your Career in Family Social Work*. Accredited Schools are listed as well as information as to fellowships and scholarships. There is also a bibliography. This booklet should prove a real aid to those in vocational guidance. Single copies are 15 cents.

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The Rev. Gordon Chambers is now Protestant Chaplain at the State Hospital in Larned, Kan. The Rev. Anton Boisen once again is serving as acting chaplain at Elgin State Hospital.

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The Postgraduate Center for Psychotherapy (218 East 70th St., New York 21) announces special orientation courses of interest to clergymen.

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The Journal of Social Casework has shortened its name to *Social Casework*. Miss Cora Kasins continues as editor.

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In reviewing *Psychic Energy: Its Source and Goal* by M. Esther Harding in our Summer issue, we neglected to mention the publishers, Pantheon Books of New York.

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The Rev. Paul Maves (co-author of *Older People and the Church*) is now Assistant Professor of Religious Education at Drew Theological Seminary.

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An interesting and informative annual report has been published by the Institute for Rankian Psychoanalysis (135 N. Perry St., Dayton 2, Ohio), and copies may presumably be secured upon request. Postage is always appreciated.

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The Rev. William R. Harris is resident chaplain of the Church Home and Hospital, Baltimore, Md.

A chaplaincy position is available in Cleveland, Ohio. Inquiries should be directed to Chaplain Carl Scherzer of the Protestant Deaconness Hospital, Evansville 11, Ind.

Applications are being received for a hospital chaplaincy in Ohio. Address all inquiries to the Rev. Reuben Coleman, Church Federation of Dayton and Montgomery County, 1600 U. B. Bldg., Dayton 2, Ohio.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., REQUIRED BY THE ACT OF CONGRESS OF AUGUST 24, 1912, AS AMENDED BY THE ACTS OF MARCH 3, 1933, AND JULY 2, 1946, OF THE *JOURNAL OF PASTORAL CARE*, PUBLISHED QUARTERLY AT BOSTON, MASSACHUSETTS, FOR OCTOBER 1, 1949.

State of Massachusetts
County of Middlesex

Before me, a Notary Public in and for the State and county aforesaid, personally appeared Rollin J. Fairbanks, who, having been duly sworn according to law, deposes and says that he is the Editor of the *Journal of Pastoral Care* and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management, etc., of the aforesaid publication for the date shown in the above caption, required by the act of August 24, 1912, as amended by the acts of March 3, 1933, and July 2, 1946 (section 537, Postal Laws and Regulations), printed on the reverse of form ℳ3526, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are: Publisher—Institute of Pastoral Care, Incorporated, Andover Hall, Cambridge 38, Mass.; Editor—The Rev. Rollin J. Fairbanks, Andover Hall, Cambridge 38, Mass.; Managing Editor—none; Business Manager—none.

2. That the owner is The Institute of Pastoral Care, Incorporated, whose officers are: President, Dean Willard L. Sperry; Secretary, Dean Charles L. Taylor, Jr.; Treasurer, Dean Walter G. Muelder. No stock has been issued.

3. That there are no known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stock, bonds, or other securities than as so stated by him.

ROLLIN J. FAIRBANKS

Sworn to and subscribed before me this 23rd day of September, 1949.

GERALD J. DOWNING
My commission expires November 18, 1953